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by

(C) PEARL MARGARET MORRISON

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Abstract

Current literature contains little information describing community health nursing managers' work, and no reports were found of observational studies of their work. The central question underlying this study was: What do community health nursing managers do in performing their role as community health nursing managers? A structured observation field study was conducted to obtain a description of the activities and administrative behaviors of community health nursing managers.

The study population was limited to full-time senior nursing managers in official community health agencies in Alberta. Four randomly-selected community health nursing managers were observed for a total of twelve days during October and November 1982. The organizations within which these managers worked were described. The twelve days of observational data were analyzed according to: (1) a molecular approach, in which the types of activity and participants in activity were considered; and (2) a molar approach, in which the purposes of activity were categorized to determine administrative behaviors. A composite description of the activities and administrative behaviors of the community health nursing managers was developed, and compared to the composite descriptions resulting from other structured observation studies of managers.

The small sample size and restricted study population limit generalizability of the findings. However, the

in-depth data and composite profiles give insight into the activities and administrative behaviors of some Alberta community health nursing managers at present. It was concluded that the community health nursing managers studied: had work days filled with a great number of short-duration activities which involved a variety of issues; had few breaks in the pace of activity; spent a larger proportion of time in joint than in solitary activities; spent a significant proportion of time in professional behaviors; spent the largest proportion of time in interpersonal behaviors, and of these, the leader role was predominant; and experienced conflict between their responsibility for community health nursing staff and programs, and their responsibility related to total Health Unit administration. The structured observation method, although appropriate for this study because it yields descriptive information regarding managerial work being done, does not give information regarding the effectiveness of the work, or prescriptive information regarding what work should be done.

It was recommended that community health nursing managers examine the descriptive information in relation to their goals to determine the appropriateness for them of the observed profiles of work characteristics and work content. Other recommendations include suggestions for further research, and advise development of an improved study methodology.

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This study could not have been conducted without the community health nursing managers who participated. Their co-operation and their candor in discussing their work were invaluable. As agreed, they remain anonymous in this report, but they are not anonymous in my thoughts.

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1. INTRODUCTION

1.1 Background to the Study

Although nurses had worked in Canadian communities as hospital, private duty and district nurses since the mid 1800s, community (public) health nurses only began to be employed during and after World War I. The number of community health nurses increased dramatically as Canadian provincial governments established full-time community health services throughout the provinces (CPHA, 1959), and as the primary emphasis in community health shifted from sanitation to health education (Emory, 1945; Hastings & Mosley, 1964/1980). Further, community health nurses are the largest single group of professionals providing community health services in North America (Leask, 1970, p. 161; Leavell & Clark, 1965, p. 558). As the number of community health nurses increased, the need for supervision and management to ensure quality service provision was increasingly recognized in both Canada (Emory, 1945, 1953) and the United States (Hanlon, 1955; Hodgson, 1939; NOPHN, 1932b, chap. 6). Despite recognition of the need for supervision, the Canadian Public Health Association (CPHA) Study Committee on Public Health Practice in Canada reported in 1950 that "Canada lacks qualified public health nursing supervision" (p. 19), and recommended that the urgent need for public health nurses prepared in supervision be

addressed (p. 18).

The challenging need for improved organization, administration and co-ordination of public health activities continued to be specified in numerous writings about community health since 1960 (Charron, 1960; Dafoe, 1974; Hastings, 1969; Ontario Ministry of Health, 1977). Although there were texts published up to 1960 which guided those directing and supervising community health nurses (Freeman, 1944, 1949; Hodgson, 1939; Freeman & Holmes, 1960; Hanlon, 1950, 1955, 1960) and community health nursing practice texts which included discussion of the need for supervision and management (Emory, 1945, 1953; Gardner, 1936; NOPHN, 1932a, 1932b), the majority of current community health nursing practice texts contain very little, if any, mention of the need for supervision, administration or management of such practice (Benson & McDevitt, 1980; Braden & Herban, 1976; Freeman & Heinrich, 1981; Hall & Weaver, 1977; Helvie, 1981; Jarvis, 1981; Leahy, Cobb & Jones, 1977; Reinhardt & Quinn, 1973; Tinkham & Voorhies, 1977). The authors of current texts who discuss management concepts do so mostly in relation to how these concepts can be utilized by staff community health nurses (see, for example, Clemen, Eigsti & McGuire, 1981, chap. 20).

The CPHA publication (1966a) titled A Statement of Functions and Qualifications for the Practice of Public Health Nursing in Canada includes functions and qualifications for directors and supervisors of public

health nursing. The 1977 replacement for the 1966 publication lists competencies and qualifications needed for organization of health care, but does not discuss the functions of the nurses involved in organization of health care (consultation, administration, education, research). Little evidence was found in other current literature of information regarding the functions required of community health nursing managers today. This lack of evidence may be due to a number of factors. For example, there is lack of documentation about what community health nursing managers do, and lack of sufficient description of what they should do; community health nursing managers have published very little material regarding their work; and management concepts have not been seen as more important for managers than for staff community health nurses. In summary, regardless of the causes of the lack of information, there does not seem to be a description of what community health nursing managers actually do. This lack of information is similar to that discussed by Mintzberg (1973a, p. 7) in relation to business management. Mintzberg, who studied chief executives of medium and large-sized firms, discussed characteristics of managerial work and the roles which managers fulfill, but suggested that follow-up studies were needed to see whether or not these were valid descriptions of other managers' work (p. 197).

1.2 Statement of the Problem

According to the literature reviewed, the activities and behaviors of community health nursing managers have not been systematically studied by observation in their actual work setting. In this study an observation of the activities and classification of the administrative behaviors of community health nursing managers is made in order to develop a description of their work within their organizations. The two levels of analysis which Kerlinger (1973, pp. 542-543) discusses in relation to measurement of human behavior, the molar and the molecular, are used in analysis of the community health nursing managers' work. "The molar approach takes larger behavioral wholes as units of observation . . . . the molecular approach, by contrast, takes smaller segments of behavior as units of observation" (p. 542). In this study specific activities (molecular approach) are observed and described, and then administrative behaviors (molar approach) are determined by categorizing activities according to purpose. (For further discussion of the analysis see sections 2.2.3.4 and 3.5.2.) The central question underlying the study is: What do community health nursing managers do in performing their role as community health nursing managers?

1.3 Significance of the Problem

The central question in this study is similar to questions raised by Mintzberg (1973a), Choran (Note 1), Duignan (1979), and Hannah (1981) regarding different types of managers. Thus, the theoretical significance of this study lies in a consideration of the similarities and differences among activities and administrative behaviors of community health nursing managers (this study), Canadian deans of nursing (Hannah), Alberta school superintendents (Duignan), managers of small companies (Choran), and chief executives (Mintzberg).

The practical significance of this study is related to the specific findings regarding activities and administrative behaviors of community health nursing managers. The information derived should be helpful: (a) in documenting the activities and administrative behaviors of community health nursing managers; (b) to prospective community health nursing managers, as descriptive information about the type of position; (c) to boards and directors as information for recruitment of community health nursing managers; (d) to educators as a guide for preparation of basic and inservice education programs for community health nursing managers; and (e) to current community health nursing managers, as descriptive information about what some community health nursing managers do.

1.4 Brief Description of the Study

A field study approach was used to obtain a description of activities and administrative behaviors of community health nursing managers. Structured observation (Duignan, 1979; Hannah, 1981; Mintzberg, 1973a) was the primary method of data collection. Three phases were involved in the research design for this study (see Chapter 3). In Phase 1 access to potential subjects was investigated, the study population was defined, the specific sample to be studied was selected, and a pilot study was conducted. Phase 2 involved data collection, all of which occurred in the Local Health Authorities, the usual working environment for the community health nursing managers studied. During Phase 3 the data were analyzed and the thesis written.

1.5 Limitations

The study population was limited to community health nursing managers responsible for delivery of community health nursing programs and services in official community health agencies in Alberta. These agencies are the 27 Local Health Authorities (LHAs) funded by Alberta Social Services and Community Health. For this study the community health nursing manager was considered to be the nurse with overall responsibility for the community health nursing staff and programs. Position titles included "Director of Nursing", "Supervisor of Nursing", and "Senior Nurse".

Generalizability of the findings from this study is limited by the choice of subjects from Alberta only, because in Canada the community health care system differs from province to province. For example, in Alberta, community health staff are employed by the Boards of the Local Health Authorities. Therefore, the provincial department has a staff rather than a line relationship to community health staff, which is in contrast to the situation in several other provinces (e.g., B.C., Sask., Man.). This difference may greatly affect the activities and administrative behaviors of the community health nursing managers.

For the purposes of this study the community health nursing manager was defined to be:

> a baccalaureate-prepared nurse,
>
> who is currently employed full-time as a community health nursing manager in an Alberta LHA, excluding Edmonton and Calgary,
>
> who has held this job full-time on an uninterrupted basis for the past calendar year (at the time of selection),
>
> who is in an LHA which has ongoing community health nursing programs but no (primary care) treatment programs,
>
> who has an LHA Director who has been in the position for at least one year, and
>
> who is willing to participate in the study.

The criteria in this definition limit the generalizability of findings of this study to community health nursing managers who also meet these criteria. All those who met the first five criteria in the definition agreed to participate

in the study, so selective participation was not a limitation in this study.

The sample size, which was limited to four community health nursing managers and a total of twelve days of observation, also restricts the generalizability of findings from this study. However, the random selection of the subjects and the comprehensiveness of data regarding activities used to classify behaviors, enabling development of a composite description of the activities and administrative behaviors of a community health nursing manager, help offset that limitation.

The reliability and validity of the data should be considered in relation to the limitations imposed by the method of data collection. The observation method has two major limitations: subjectivity of the observer is difficult to avoid; and the subject's activity and behavior in the presence of an observer may not be the same as when the subject is not being observed. Further, the time spent by the subjects on activity related to the observation remains unclassified and it is not known how that time would have been spent if the observer was not present. However, the observation method was preferable to other methods because data collected on actual working activity and behavior rather than reported or recalled activity or behavior is likely to be more valid and inclusive. The latter point is particularly important when large amounts of data are required for each subject. Since the objective in this study

was to observe the content of work, that is what was done rather than how or how well activities were done, the advantages of the observation method were considered to outweigh the limitations.

Observation of the subjects in this study occurred during October and November; thus, the findings may not be representative of the range of the community health nursing manager's activities and administrative behaviors throughout a year.

All community health nursing managers studied were female; at the time of the study there were no male community health nursing managers in Alberta. At present male community health nurses and community health nursing managers are few in number throughout Canada (Hastings et al., 1981; Statistics Canada, 1980).

1.6 Organization of the Thesis

This thesis consists of five chapters and four appendices. The preceding introductory material forms Chapter 1. A review of selected literature is reported in Chapter 2. In Chapter 3 the methodology used in this study is described and the results of the study are presented and discussed in Chapter 4. A summary of the study and conclusions drawn are included in Chapter 5. The appendices include a map of Alberta Local Health Authorities, correspondence sent to study participants, samples of the

data collection instruments and the summary sheets used in data analysis, and detailed results of the study.

2. REVIEW OF SELECTED LITERATURE

A review of selected literature was made as a basis for study of the activities and administrative behaviors of the community health nursing manager. Three major areas of literature were reviewed and are discussed in this chapter:

1. nursing management literature including community health nursing management literature,
2. methodological literature related to observation field studies of manager's work, and
3. community health literature related to the development and current structure of Alberta community health services.

2.1 Literature Related to Nursing Management

The literature related to nursing management is discussed in four sections: (1) nursing management models, (2) the role of the nursing manager, (3) community health nursing management and community health nursing managers, and (4) a summary.

2.1.1 Nursing Management Models

Currently in nursing management the use of "borrowed" theory predominates (Stevens, 1979, p. 113). Stevens (chap. 9) states that managerial models can be classified into four groups according to their subject matter:

1. those which focus on the structure in which management occurs,
2. those which focus on the nature or sequence of managment processes,
3. those which focus on the content of management to which the processes are applied, and
4. those which focus on the perceptions, acts, roles or other aspects of the manager.

In attempting to classify major nursing management models, this researcher considered that a fifth category was required, that of a focus on synthesis (see Table 1). The nursing management models of Clark and Shea (1979), Arndt and Huckabay (1980) and of Stevens (1980) appear to synthesize foci rather than having a single focus. Clark and Shea utilize a systems theory framework to discuss the functions of nursing management related to the health care environment; they present the major role of the nurse-manager as that of change agent. Thus, aspects of structure, content and manager foci are included in their model. The nursing management model proposed by Stevens incorporates five components: goals, structures, processes, resources and controls. She discussed nursing management as a fusion or synthesis of nursing and management. Her model includes aspects related to structure, process, and the manager.

Arndt and Huckabay (1980) have developed an administrative theory in which the processes of

Table 1

Subject Matter of Management Models

Focus of model	Examples of management models	Examples in nursing management literature
Structure of organization	Organizational models (Perrow, Likert)	Stinson Note 2
		Magula 1982
	Contingency model (Fiedler)	
Process of management	Management by objectives	World Health Org. 1958
	Management cycle (plan-organize-direct-control)	Douglass & Bevis 1979 (some role emphasis)
	Systems models (input-thruput-output)	Ganong & Ganong 1980 (some role emphasis)
		Clemen et al. 1981 (some structural emphasis)
Content of management	POSDCORB (plan, organize, staff, direct, coordinate, report, budget)	Finer 1952
		DiVincenti 1972 (some structural emphasis)
	Managing of tasks-managing of workers models (e.g., Blake-Mouton managerial grid)	Donovan 1975
		Brancich & Porter 1979
Perceptions, acts or roles of manager	Motivation (McClelland)	Claus & Bailey 1977
	Acts (Ohio State University, Simon)	
	Leadership traits or styles (e.g., Stogdill)	
	Perspectives (McGregor)	
	Roles (Mintzberg)	
Focus on synthesis		Clark & Shea 1979
		Arndt & Huckabay 1980
		Stevens 1980

Note. Based on "Theory of nursing administration," Chap. 9 in B. J. Stevens, Nursing theory: Analysis, application, evaluation. Boston: Little, Brown & Co., 1979. The first four categories of focus and the examples of management models are from Stevens; the fifth category and the nursing management examples are proposed by this researcher.

administration are considered within a systems theory framework. The process model within their theory is termed the Administrative Composite Process and includes two categories of administrative acts: conceptual (planning and organizing) and physical (directing and controlling). The acts of planning, organizing, directing and controlling are considered to be the interdependent functions of management. Arndt and Huckabay stated that a synthesis of administrative thought was needed to evolve an eclectic theory of administration; it appears that their theory is a synthesis of concepts from several management models. Three interdependent administrative levels are listed by Arndt and Huckabay: technical, which is concerned with actual task performance within the nursing department; organizational, which is concerned with co-ordination and integration of the task performance; and institutional or community, which is concerned with relating the organization's activities to the external environment.

It appears that a major contribution of nursing management authors is the synthesis of management models and theories. In addition to the three models which this researcher included in the synthesis category, other nursing administration models which appear to have a secondary focus in addition to their primary focus are noted in Table 1 (Clemen et al., DiVincenti, Douglass & Bevis, Ganong & Ganong).

Two general management models appear to be the bases for most of the nursing management literature:

1. the planning-organizing-directing-controlling cycle, which Stevens included as a model with focus on the invariate sequential processes applied to the diverse content of management (see, for example, Clemen et al., 1981, chap. 20; Douglass & Bevis, 1979, chap. 1 & 2; Ganong & Ganong, 1980, chap. 1; WHO, 1958, pp. 11-18), and
2. the POSDCORB functions of management (planning, organizing, staffing, directing, co-ordinating, reporting, budgeting) which Stevens included as a model with focus on the specific content areas to which the management processes are applied simultaneously (see, for example, Donovan, 1975, part 2; Finer, 1952, chap. 11).

Although Stevens clearly distinguishes the sequential process focus of planning-organizing-directing-controlling from the content focus of POSDCORB, some authors of nursing management literature seem to utilize the planning-organizing-directing-controlling model as a framework to categorize functions of management (see, for example, Brancich & Porter, chap. 21 in Archer & Fleshman, 1979; DiVincenti, 1972, part 2). In the books by Arndt and Huckabay (1980) and Ganong and Ganong (1980) the terms "processes of management" and "functions of management" seem to be used almost interchangeably, which is confusing when

the distinction Stevens makes is used as a basis for categorizing models. The nursing management models which fit into the categories of primary focus on process, content, structure and the manager will now be discussed.

2.1.1.1 Nursing Management Models which focus on Process

The planning-organizing-directing-controlling cycle originated with the writings of Fayol and Urwick. Fayol listed five aspects of management which formed the management process: planning, organizing, command, co-ordination, and control. He also listed what he considered were universal administrative duties and principles (Fayol, 1923/1937). Urwick pointed out that Fayol had really intended that there be six categories in the process, because the French verb he used (prevoyance) meant both forecasting and planning. Thus, the sequential steps in administration as listed by Urwick are: forecasting, planning, organization, co-ordination, command and control (Urwick, 1943). Urwick's major contribution was in integrating the management theory developed up to the 1930s (Khandwalla, 1977, chap. 4; Marriner, 1979). Urwick discussed Fayol's theory in relation to writings of Follett, Mooney and Reiley, and Taylor (Urwick, 1937).

Urwick's presentation of Fayol's process of administration formed the framework for the 1958 World Health Organization publication, Principles of Administation applied to Nursing Service, which was prepared to assist

nursing service administrators and those studying principles of nursing administration. The principles were applied to hospital and public health nursing service administration, and useful techniques of nursing administration such as personnel policies were discussed.

The similarities and differences between management and leadership are discussed by Douglass and Bevis (1979). They state that both management and leadership are learned behavior patterns, that many of the processes used by leaders and managers are the same, but that most of the functions are not. They list the processes of management as planning, staffing, budgeting, co-ordinating and controlling.

The processes of management have been condensed to the three steps of planning, doing, and controlling by Ganong and Ganong (1980, chap. 1). They include organizing within the planning step, and consider doing as encompassing directing and implementing. They discuss similarities among the management process, the nursing process and the scientific method. The management process is utilized in the nursing manager's three areas of responsibility: patient care management, operations management, and human resources management.

In a chapter titled "Utilizing management concepts in community health nursing" by Clemen, Eigsti and McGuire (1981, chap. 20), management is discussed as a cyclic process with five elements: planning, organizing, directing,

co-ordinating and controlling.

2.1.1.2 Nursing Management Models which focus on Content

POSDCORB is an acronym which stands for planning, organizing, staffing, directing, co-ordinating, reporting and budgeting. It was developed by Gulick from Fayol's analysis of management to describe the major functions of the chief executive (Gulick, 1937, p. 13).

In what has been called the first book on nursing service administration (Donovan, 1975, p. 5), Finer utilized Gulick's framework of management functions, but adapted it to APOSDCORB (1952, chap. 11). The initial A represented "the attuning of the executive to the purpose and ethos of the administration" (p. 174), which Finer suggested was a crucial addition. Finer also maintained that all nursing service personnel had some need of administrative knowledge. The text written by Finer was the result of the 1950-51 Kellogg Foundation Nursing Service Administration Research Project, in which nurses and nursing teachers worked together to develop a guide for application of administration and the social sciences to nursing service (preface). Such a project was necessary because of the paucity of literature related to nursing service administration (p. 15). The major focus of the study was on nursing in the hospital (p. 24).

Finer's adaptation of the framework to describe management functions, APOSDCORB, was the basis used in

Donovan's text (1975). She also considered controlling as a separate function. Applications in the text were centered on hospital nursing service (p. 5), although Donovan stated that the text should be equally applicable to other facets of nursing. One major premise she stated was that administrative principles and practices were the same at all levels of nursing service.

DiVincenti (1972, part 2) grouped management functions as planning, organizing, leading and controlling. Her focus is definitely on hospital nursing service, as she states in the preface (p. xiii) that "nursing service administration is primarily concerned with making its share of the hospital organization effective through the process of management."

The four categories of planning, organizing, directing and controlling are used by Brancich and Porter (1979) to discuss the functions of nurse-administrators in community health nursing administration.

2.1.1.3 Nursing Management Models which focus on Structure

There appears to be little nursing management literature which focuses primarily on the organizational structure in which management occurs (for a major exception, see Magula, 1982). In many nursing management texts some variables of organizational structure within which nursing management occurs are discussed, but this is not the primary focus (for example, Clark & Shea, 1979, chap. 1 & 2; DiVincenti, 1972, parts 1 & 2; Stevens, 1980, part 2).

The book by Magula (1982) is a series of excerpts from organizational theory literature interspersed with her comments which indicate the application of the theory to nursing executives in hospitals. Organizational structure is considered to be a pattern of relationships and its design has significant effects on the work of those within the organization. Variables relevant to organizational design, such as environment, size, technology, power and change, are reviewed and their effects on nursing administration considered.

A framework for analyzing nursing administration which has a structural focus has been developed by Stinson (Note 2). The framework consists of a set of nineteen interdependent variables which have effects on nursing administration.

One concept which has received considerable attention in recent nursing management literature is the concept of power (see, for example, Claus & Bailey, 1977; Nursing Administration Quarterly, Spring 1978). Although the concept of power relates to the nursing manager, the discussion of power in nursing management literature frequently focuses on its structural determinants. It has been stated that nursing has been embedded in the administrative hierarchy of bureaucratic organizations and that top-level management positions have traditionally been held not by nurses but by men with management training (Lamb, 1973; Yeaworth, 1978). This statement is supported statistically; 75% or more of

the jobs in health care and 98% of nursing positions in North America are held by women, yet women hold less than 25% of the senior executive positions in health care (Brown, 1978; Dixon, 1980, pp. 24, 53; Dixon & Barnsley, 1980a; Grissum & Spengler, 1976, p. 53). Power does not have an entirely positive connotation in the minds of many nurses (Larsen, 1982); however, Mussallem (1977) maintains that it is the responsibility of the nursing profession to utilize political action to seek the "best possible health care for our citizens" (p. 180).

Although the nursing administrator has had legitimate power within the nursing department based on her position and title, she has not always had sufficient reward or coercive power; that is, the ability to hire and fire, make budget decisions, grant staff development opportunities, redesign nursing jobs (Larsen, 1982; Shiflett & McFarland, 1978). Referent power; high status and visibility which means one is seen by others as a respected role model, and informational or associative power, gained through membership in informal inner circles, have often been lacking for the nursing administrator. This lack has interfered with her potential ability to influence the organization in major decisions related to patient care (Larsen; Shiflett & McFarland; Beatty, Note 3). Expert power, based on knowledge, abilities and credibility, for nursing administrators arises from two sources: professional nursing and management. Traditionally, nursing managers have

been expert nurses but have had little management training; this lack has hampered their effectiveness on the management team (Larsen, Shiflett & McFarland). The need for two different types of expertise has caused conflict for the nursing manager (Shiflett & McFarland), a conflict similar to that caused by the professional versus the management requirements of the nursing manager's role.

2.1.1.4 Nursing Management Models which focus on the Manager

Stevens stated that the management studies which focused on traits and styles of leaders "shifted study away from management to leadership" (1980, p. 193). This emphasis on leadership is evident in nursing management literature (see, for example, Berger, Elhart, Firsich, Jordan & Stone, 1980, chap. 6; Marriner, 1979; Nursing Administration Quarterly, Fall 1976).

A Power/Authority/Influence Model is proposed by Claus and Bailey (1977) as an approach to leadership. These authors are concerned with the manager's role as leader and concentrate on the positive use of power by leaders in order to influence health care. Personal, organizational and social bases of power are discussed. Four basic functions of management (planning, organizing, directing, controlling) are discussed in relation to organizational power.

Some other current texts focus exclusively on leadership (Epstein, 1982); others discuss both leadership and management (Douglass & Bevis, 1979). Douglass and Bevis

maintain that leadership can be assumed, but that management is a legitimately designated position with the manager's authority arising from both superiors and subordinates. Since this study is concerned with managers in legitimately designated positions, leadership literature will not be discussed further. Literature related to the role of the nursing manager, a major focus of this study, will be reviewed in the next section.

2.1.2 The Role of the Nursing Manager

> At no other time in the history of Canadian nursing has the field of nursing administration and the role of the nursing administrator received the level of interest and recognition it has in this seventh decade [1969-1980]. (CNA, 1981, p. 7)

Although this statement was made about Canadian nursing, it would appear that there has been an increased level of interest in the role of the nursing administrator in both Canada and the United States.

One indicator of the increased level of interest is shown by the dates of publication of the nursing management literature discussed in section 2.1.1. Of the fourteen references to nursing management models, two were published during the 1950s, nine had the first edition published during the 1970s, two have been published in the 1980s and one has not been published.

Recognition of nursing administrators as a group with specialized interests and needs has also been indicated by journals which began publication during the 1970s and by

national conferences for nursing administrators held in both the United States and Canada since 1978. Journals which began publication during the 1970s include Journal of Nursing Administration, Supervisor Nurse, Nursing Administration Quarterly, and Nursing Leadership. In the United States the first national nursing administration conference was held in 1978 (Report, 1978) and a nursing administration research conference was held in 1981 (Notices, 1980). In Canada the first and second national nursing administrator's conferences sponsored by the Canadian College of Health Service Executives were held in 1980 (Wood & Zilm, 1980) and 1982 (Nurse managers, 1982), and the National Nursing Administration Forum sponsored by the Canadian Nurses' Association was held in 1981 (People, power, potential, 1982). These journals and conferences provide nursing administrators with relevant information, help to develop the informal networks which assist executives to learn to do their jobs better, provide awareness of job opportunities for themselves and others whom they wish to help advance (Daniels, 1977; Ruzek, 1977; Wood & Zilm, 1982, p. 2), and assist in counteracting the isolation which Labelle (1980) says every director of nursing must face as part of the job.

Other recent events would seem to indicate that the needs of Canadian nursing executives required a more specific focus than they had previously received. In 1976 for the first time a member-at-large representing nursing

administration was elected to the Canadian Nurses' Association Board of Directors (CNA, 1981, p. 25). In 1981 the Canadian College of Health Service Executives appointed the Nursing Administration Advisory Council to the Board; this council was to make recommendations to the Board regarding the College's role in meeting professional and educational needs of nursing executives (CCHSE, 1981). During 1981-82 the Executive Nurses' Association of Alberta was established; its members include nurses who are in top-level administrative positions or who held such positions within the past five years (ENAA, Note 4). Canadian Nurses' Association members passed resolutions regarding education for nursing administrators at their 1980 Annual Meeting (CNA, 1981, p. 30). In response, the CNA Board commissioned a discussion paper (Leatt, 1981), and established an ad hoc committee to develop a document regarding roles of nursing administrators and standards for nursing administration (Preparation, 1982). The committee document was approved by the CNA Board at their February 1983 meeting and will be published (CNA, in press; Kerr, Note 5).

This recent Canadian concern regarding education for nursing administrators is similar to relatively recent concerns expressed about the same issue in the United States. Several conferences regarding education for nursing administrators were held in the United States in 1976 and 1977 (Proceedings, 1977; Slater, 1978). The conference

proceedings and other literature show that there is considerable controversy regarding the appropriate emphases in content of education for the nursing executive. Advanced-level study in clinical nursing has been advocated, although usually it is intended that this be combined with managerial training (Arndt & Huckabay, 1980; Christman, 1978). Peterson (1978) suggested that the clinical component of nursing administration education be redefined as planning for groups of patients rather than focusing on patient care in one-to-one contacts. Other authors insist that, although the nursing administrator needs to be a nurse, she does not need additional clinical nursing preparation, but does need administrative preparation (Kinsella, 1977; Rotkovich, 1979). Still another position has been stated as "because of its unique properties, the practice of nursing administration requires unique preparation" (McClure, 1979, p. 11); Stevens (1978) describes this unique preparation as a synthesis of nursing and management. To gain the broad administrative background needed by top-level nursing administrators, their education should occur in interdisciplinary health services administration programs which have considerable, but not exclusive, nursing administration emphasis argues Stinson (1977, 1978).

A major reason for the controversy regarding the appropriate educational preparation for the nursing manager would seem to be the lack of clear definition of the role of the nursing manager. Stevens (1981) states that the concept

of role involves a set of expectations concerning how a person will enact a given societal position, and that the concept includes both the person and the acts of that person.

2.1.2.1 Studies of the Nursing Manager Role

Several studies aimed at obtaining a clearer picture of the role of director of nursing in the hospital setting have considered either the director's own perceptions or others' expectations concerning the role. Directors of nursing in 69 U.S. hospitals of under 200 beds were surveyed by questionnaire regarding their managerial practices (Chapman, 1968). Chapman concluded that, in fact, most hospitals did not employ a full-time director of nursing, because many of the directors spent considerable time in other special hospital administration services and in patient care activities.

Monahan (1968) surveyed by questionnaire and interview 58 directors of nursing in eastern U.S. hospitals of 100 - 400 beds to identify their perceptions of functions and problems of nursing administration. She found that these directors' activities tended to be limited to those directly concerning the nursing department.

A questionnaire survey of 213 directors of nursing, hospital administrators, clinical specialists, and head nurses in 37 U.S. hospitals of 145 beds or more was conducted by Hamilton (1970) in order to examine the

director of nursing position. She concluded that no consistently discrete area of responsibility emerged from the perceptions of all groups which could be identified as the director's domain.

Poulin (1972) interviewed administrators of nursing service in 9 selected U.S. hospitals of over 300 beds to acquire information about the structure and functions of the nursing administrator's position. She concluded that the functions of the director were changing, that the role was far from clearly defined, and that the multiple administrative demands on the position and nursing's focus on clinical practice as the true professional role were sources of potential conflict for the nursing administrator.

A questionnaire survey of 889 directors of nursing in U.S. hospitals of 200 - 2300 beds was conducted by Erickson (1972) to study the hospital nursing administrator position. She concluded that clinical nursing practice was of minor importance in the director's position, but that the director should be a nurse as nursing <u>knowledge</u> was required. She found that the director's position was oriented more toward top-level management activities than to middle-management supervisory activities.

In 1980 Erickson published a review of important studies regarding the nursing director's role which had been conducted from 1880 to 1980. From 1880 through the 1930s the director of nursing service (at that time usually called the superintendent) was frequently also the director of the

school of nursing and the hospital superintendent. Erickson stated that the 1950-51 Kellogg Foundation project established the distinction between nursing education and nursing service administration and the need to separate these two functions. She concluded that "the position of the hospital nursing service administrator has changed as hospitals, demands for health care, medical technology, government regulations, concepts of management, and nursing have changed" (1980, p. 12).

In a study of 47 directors of nursing in California hospitals, Arndt and Laeger (1970) found that three-quarters of them were concerned about role ambiguity; that is, they were uncertain about the scope and responsibilities of their job and of what was expected of them by their co-workers. Three-quarters of the directors identified many different role senders whose demands were hard to predict and control. These role strains caused a high level of stress for the directors.

McCullagh (Note 6) in interviews with directors of nursing in Alberta hospitals found that, although they received many types of information at frequent intervals, they did not receive feedback regarding the performance of the nursing department from the hospital board, and only in exceptional and infrequent circumstances from the administrator, their management peers and their subordinates. Feedback regarding their own performance was even less frequently received; three of the six directors

had never received an assessment of their performance from the administrator or the board.

All of the previously-discussed studies of the role of the nursing manager were conducted with hospital nursing managers as subjects; similar studies of community health nursing managers were not found. The major finding of the studies reviewed was that the nursing manager's role was not clearly defined and the role expectations were unclear.

2.1.2.2 Role Perceptions of Directors of Nursing

Directors of nursing have reported on their own perceptions of their role. Recent reports of their perceptions of the primary role responsibilities as summarized include: to provide leadership (Moore, 1976), to manage patient care, human resources and fiscal resources (Donaho, 1977), to assist staff so that nursing's responsibilities to the patient and family, to the community and to the profession are met (Simmons, 1977), to be prime facilitators with a sense of balance and flexibility, to be delegators of responsibility, and sources of support (Lukasik, 1977), to be clinically competent, to be a manager and a teacher with emphasis on effective development of subordinates (Brueckner, 1978), to give leadership to nursing through the use of administrative skills and knowledge (McClure, 1979), and to be an effective leader of nurses and a facilitator in the health care system (Nyberg, 1982).

Educators reported nursing executives as describing their roles as expert clinician, manager, educator or human relations expert (Stevens, 1980, 1981); and as leader or manager more often than as nurse, educator, researcher or consultant (Leatt, 1981).

Role change and role conflict were reported by directors as well. The top-level nursing administrator has changed focus from clinical practice to management practice and has often ignored the grief process associated with this change (Donaho, 1977).

> The specific professional administrative role conflict for the nursing administrator is a conflict between the professional goal of optimal nursing care and the administrative goals of economy and efficiency. (Brueckner, 1978, p. 11)

2.1.2.3 Nursing Educator's Descriptions of the Nursing Manager Role

Nursing educators describe the role of the top-level nursing administrator as: to manage social impact and social responsibility, to contribute to the mission and goals of the organization, to make work productive and the employees achievers (Schaefer, 1977); to incorporate the multiple roles related to interdisciplinary, health care systems, human relations, nursing, and administrative responsibilities (Kelly, 1977); to provide executive-level leadership primarily for nurses and nursing which involves many roles (planner, educator, developer, conciliator, risk-taker, standards-bearer, innovator, and so on)

(Stinson, Note 7); to be one of innovator, expander, refiner, stabilizer, or revolutionary (Stevens, 1980, 1981); and to provide leadership in nursing (a professional dimension), and to be a member of the management team of the organization (a corporate dimension) (Leatt, 1981). Rowland and Rowland (1980) refer to a 1977 National League for Nursing publication in which the role of the director of nursing service is discussed as having three facets: an experienced nurse with influence in nursing who can be an interpreter for nursing, a management colleague at the top administrative level, and an educator.

Schaefer (1977) asserts that nursing administrators, when effective, do not practice nursing, for the understandings and skills of administration are not the same as those required for the practice of nursing. Kelly (1977) says that the director of nursing role is changing and is subject to considerable conflict and confusion.

> Her credibility [within nursing] depends on her ability to nurse, rather than to lead, but in the long run she is expected to do both. One hardly expects a top level executive in industry to work on the production line, but in nursing we still expect nurses to be all things to all people. We thereby dilute their energy and diffuse their purpose. (LeRoux, 1976, p. 25)

The conflict and controversy regarding the role of the nursing manager has been summed up by Leatt:

> Currently in Canada there is no consistent definition or interpretation of the role expectations, role relationships and skill inherent in the role of the nurse administrator. (1982, p. 59)

2.1.2.4 Mintzberg's Model of Managerial Roles

One management model regarding roles which is referred to in recent nursing management literature is Mintzberg's model of managerial roles (1973a, 1975), which was developed from his study of chief executives in medium and large organizations (see section 2.2.1). Stevens (1979) includes Mintzberg's model with those which focus on the manager as opposed to focusing on structure, process or content of management.

In her 1980 text Stevens discusses Mintzberg's model of ten managerial roles (1975) in a chapter on the role of the nurse executive, and states that "different nurse executives may spend different amounts of time on each, but it is difficult to imagine an effective nurse executive ignoring any one of them" (p. 199). Chater (1981) utilizes Mintzberg's model of ten managerial roles (1975), along with situational models, to help her understand her management position within the university. In the Nursing Administration Handbook (Rowland & Rowland, 1980) the characteristics of managerial work and the manager's roles are copied from Mintzberg (1973a) without discussion. Mintzberg's major categories of managerial roles, interpersonal, informational, and decisional, (1973a) are used as categories in an instrument developed to assess and improve the functions of top-level nursing and other management teams in hospitals (Pointer & Strum, 1981; Pointer, Strum & Scalzi, 1981). Eight categories of skills

which Mintzberg (1973a, chap. 7) listed as important for managers to learn are included in Claus and Bailey's discussion of translating power into influence (1977, p. 85). In a text oriented toward first-line nurse managers, Keane (1981, chap. 2) utilizes Mintzberg's model of managerial roles (1975) to discuss the roles of the nurse manager. She emphasizes the interpersonal roles of leader and liaison, the decisional roles of resource allocator and disturbance handler, and two other roles of special importance to the nurse manager, which she terms evaluator, and teacher and developer of resources.

Stevens (1979, pp. 124-125) cautions that nursing managers must not "borrow management theories indiscriminately", and must consider whether or not a theory is consistent with the dominant characteristics of the nursing environment, is useful in managing the work, and addresses the elements of management most significant in the nursing environment. Only two reports of studies which tested Mintzberg's model of managerial roles with nursing managers were found: a study of head nurses in a Texas hospital (Jones & Jones, 1979) and one of deans of nursing in Canadian universities (Hannah, 1981).

In the study reported by Jones and Jones eight head nurses and assistant head nurses in a 106-bed hospital were observed over a period of four months. Although specific procedures are not identified the authors state that "all significant work activities performed by each head nurse

were identified and then classified in terms of one of Mintzberg's ten roles" (p. 49). They found that the observed head nurses spent about 10% of their time in interpersonal activities, about 15-20% of their time in informational activities, and about 75-80% of their time in decisional activities. They then propose a normative model which they describe (p. 54) as "a better balanced activity role set for head nurses" (30% of time on interpersonal activities, 40% on informational activities, and 30% on decisional activities). However, they do not clearly indicate how the decision was made that this division is more appropriate than the observed or other possible divisions of time among the types of activities; it seems to have been an arbitrary decision. Hannah's study (1981) will be discussed in the methodology section (see section 2.2.2).

The role of the nursing manager received increased attention during the 1970s and early 1980s. Indicators of this increased attention included new nursing management texts and journals, national conferences for nursing managers, nursing management positions in professional associations, and studies of the nursing manager's role. The majority of the texts, journals and studies focused on hospital nursing management; literature related to community health nursing management will be reviewed in the next section.

2.1.3 Community Health Nursing Management

Supervision in Public Health Nursing (Hodgson, 1939) and Techniques of Supervision in Public Health Nursing (Freeman, 1944, 1949) were early books relevant for those directing public health nursing services. Hodgson stated that no books had yet been written especially for the guidance of the public health nursing supervisor (Preface). Hodgson discussed the supervisor as the person overseeing the nursing service and the director of nursing as the head of a nursing service who had supervisors reporting to her (p. 104). Both required abilities as a leader, teacher and administrator although the relative emphases varied. The need for supervision in public health nursing was probably increasing due to rapid expansions in the public health field, increasing complexity of public health programs, and higher expectations of nursing (Freeman, 1944, chap. 1). Freeman stated that "the primary purpose of supervision is the betterment of the public health nursing service" (p. 10). Finer (1952, p. 176) stated that the texts by Hodgson and Freeman were "hardly distinguishable from general books on administration" and he considered the word "supervision" in their titles a misnomer.

The only book which specifically refers to Canadian community health nursing is Emory's Public Health Nursing in Canada: Principles and Practice (1945, 1953). Although Emory stated that she wrote the book for students of public health nursing, there are several chapters on the organization,

administration and supervision of public health nursing service which would be useful to persons with those tasks.

The majority of the nursing administration models discussed in sections 2.1.1 and 2.1.2 focus on nursing management in hospitals. Some of the authors indicate their focus directly (e.g., DiVincenti, Magula); some indicate the focus less directly by the use of examples and applications related to hospitals (e.g., Donovan, Douglass & Bevis); and others utilize hospital examples almost exclusively, but suggest that the materials should be applicable to other settings (e.g., Finer, Ganong & Ganong). All of the studies of the nursing manager's role reported in section 2.1.2.1 were conducted with hospital directors of nursing, and neither of the studies which tested Mintzberg's model of managerial roles (section 2.1.2.4) were conducted with community health nursing managers.

The only authors noted in section 2.1.1 who discussed community health nursing management directly or used examples related to community health nursing management were WHO (1958), Brancich and Porter (1979), and Clemen et al. (1981). Clark and Shea (1979) had chapters which referred to the home health agency (the U.S. equivalent of home care), the health systems agency (a health planning and regulating system in the U.S.), and non-traditional health care delivery systems, but did not discuss traditional community health nursing. Principles derived from Fayol's process of administration were applied to public health nursing service

administration in the WHO publication. Clemen et al. discussed the managerial process as applied to community health nursing and stated that community health nurses must utilize management concepts in order to handle their diverse and multiple responsibilities (pp. 580-581), although the director of nursing "will probably spend more time in managing than the staff nurse" (p. 556).

In discussing the division of labor among three different levels of community health nursing personnel, Brancich and Porter distinguish a different focus of service for each level (1979, pp. 553-558), a distinction which seems to be based on the typology of community health nursing practice reported earlier by Archer (1976). Direct client service is the major responsibility of community health nursing staff, semidirect client service (day-to-day staff supervision and program planning) is the major responsibility of supervisory personnel, and indirect client service (resource allocation, intra and extra-organizational relations, research and program development and evaluation) is the major responsibility of the directors of nursing. They emphasize that these functions are complementary and overlapping. Their category of semidirect client service seems to be similar to what Anthony and Herzlinger term operational control, which is ensuring that day-to-day activities are carried out effectively and efficiently. Indirect client service seems to be similar to Anthony and Herzlinger's management control with its four phases of

programming, budgeting, operating and measurement, and reporting and analysis (1980, chap. 1).

Professional associations seem to have been a major source of literature relevant to community health nursing management. The National Organization for Public Health Nursing (NOPHN) in the United States, as well as publishing the journal Public Health Nursing, published such books as the Manual of Public Health Nursing (1926, 1932), Principles and Practices in Public Health Nursing including Cost Analysis (1932), and Survey of Public Health Nursing: Administration and Practice (1934). In 1952, after 40 years as the recognized spokesman for public health nursing, the NOPHN joined with two other organizations to form the National League for Nursing (NLN; Hanlon, 1969, pp. 590-591). NLN has published numerous references for community health agencies; some recent examples are those related to accreditation, statistical reporting and management information systems (1976, 1977, 1978).

The Committee on Administrative Practice of the American Public Health Association developed a manual of administration for community health, which was first published in 1927, with subsequent revisions published in 1932, 1939, and 1950 (Hiscock, 1932, 1950). These manuals each included chapters on public health nursing. In Canada the Canadian Public Health Association (CPHA) publishes the Canadian Journal of Public Health, and has published such references as those regarding the development of public

health in Canada (1940, 1959), public health practice (1950), recruitment of public health personnel (1969), and functions and qualifications of community health nurses (1966a, 1977).

Books written specifically for community health nursing managers published more recently than the 1950s were not found, although there are chapters related to community health nursing in Hanlon's text on public health administration (1969, 1974; Hanlon & Pickett, 1979), and the discussion in Freeman and Holmes 1960 text includes the different professional disciplines, including public health nursing, which are part of the management team in public health. They state that "in public health services, administration is a diffused rather than a centralized responsibility" (p. 24). They describe administration as a process which includes planning, mobilizing, co-ordinating, guiding, liberating and accounting (chap. 2).

Resource material relevant to community health nursing managers is not readily available in journals either. Mazurenko (Note 8) reviewed community health nursing administration literature and concluded that the needs of practicing community health nursing managers for current readily available literature in their field were not being met. She noted several issues relevant to Canadian community health nursing administrators which had not been discussed in the journals reviewed.

2.1.3.1 Community Health Nursing Managers

The 1950 report of a study of Canadian public health practice included the statement "Canada lacks qualified public health nursing supervision" (CPHA, 1950, p. 19). In 1977 (Flaherty, Note 9) and 1982 (Leatt) a shortage of nurse administrators was reported; although these reports referred to nursing administrators in general there is no reason to believe that the shortage is less acute in community health nursing administration.

Emory (1945, chap. 8) distinguished two levels of community health nursing administration as Hodgson had previously. The director, who was the chief nursing executive, had at least four clearly defined areas of responsibility: to the Medical Officer of Health or board, to the staff, to the community and to the organized profession. The supervisor, who was responsible to the director, had two functions, administrative and educative, and the ultimate objective of supervision was to enable the public health nurse to render a high level of service to the public (chap. 11). This objective is very similar to the primary purpose of supervision stated by Freeman.

In response to a 1964 resolution from its Public Health Nursing Section, CPHA established a committee which developed A Statement of Functions and Qualifications for the Practice of Public Health Nursing in Canada. Functions and qualifications are listed for two levels of administration: the director of public health nursing and

the supervisor of public health nursing. The director was the senior nursing person in the organization reporting to the chief administrator or to the board, and was a member of the administrative team. She had decision-making authority in relation to the entire range of nursing and participated in policy planning for the organization. The supervisor was responsible to the director and had two major responsibilities, the promotion of quality of public health nursing services and the development of staff (1966a, p. 4).

In 1976 the CPHA Committee on Public Health Nursing requested updating of the 1966 document of functions and qualifications. The document which resulted (CPHA, 1977) distinguishes two categories of nursing service in community health: direct care services and health care organization. Direct care services include health promotion, prevention, health maintenance and personal care. Health care organization includes consultation, administration, education and research. Specific positions and qualifications are not listed for the separate aspects of health care organization (pp. 4-5). Qualifications are listed as a master's degree in nursing or related field (e.g., administration) or a doctoral degree. Competencies needed in health care organization are listed as the ability to: collaborate as a member of a multi-disciplinary team, organize and co-ordinate nursing services, initiate and participate in nursing and health research, participate in education of nurses and other health professionals,

collaborate in policy development and development of standards for care (p. 7).

In a commentary on the public health nursing supervisor role (Knollmueller, 1979), the demise of the staff development function of the supervisor was noted. This function was considered essential to the effectiveness of the services offered and concern was expressed that without effective supervision the quality of community health nursing has suffered. These supervisory functions of staff development and quality assurance were specifically listed as responsibilities of the Canadian supervisor of public health nursing in 1966 (CPHA 1966a), but no reference to them was included in 1977 (development of standards was included, but not quality assurance). It would seem that Knollmueller's expressed concern should be considered and dealt with in Canadian community health nursing.

Few literature references were found which reported studies of community health nursing manager's work. In a review of 115 journal articles related to community health nursing research published from 1972 to 1976 (Highriter, 1977), no studies of the community health nursing manager's activities or role were reported.

A study of the self-reported activities of 160 nursing personnel in Alberta Local Health Authorities was conducted in 1968 (Ebert & Macalister, 1970); it was based on a similar previous study in Ontario (CPHA, 1966b). In the Alberta study nineteen supervisors from one city health

department and ten health units were included in the study sample. On average, the supervisors spent about 25% of their time in nursing service, 30% in administration, 18% in recording and clerical activities, 11% in travel and 15% in all other activities (community relations, activity study and personal activities). Of the 19 supervisors, only 5 did not have nursing service responsibilities in addition to their supervisory duties. The Ontario study included 127 nurses in six health units and municipal health departments. Directors of nursing on average spent about 8% of their time in nursing service and supervisors spent about 13% of their time in nursing service. Two other reported studies of utilization of community health nursing time did not include administrative personnel as subjects of study (Brown, 1980; Kissinger, 1973).

In 1976-77 a survey of 391 community health nurses employed in Alberta Local Health Authorities was conducted for the purpose of obtaining information regarding community health nursing manpower and programs (ASSCH, 1977). It was found that 67% of Alberta community health nurses had a baccalaureate nursing degree or a diploma in public health nursing; 63% of the community health nursing supervisors surveyed had a baccalaureate nursing degree and an additional 16% had a diploma in public health nursing (pp. 10, 13). It was also noted that 15% of the community health nursing work force worked part-time (p. 15). The emphasis was on the staff community health nurses' responses; the

only result reported specifically for supervisors other than their educational preparation was that 89% of them regularly read more journals than did their staff nurses.

The 1977-78 Canadian Health Administrator Survey (Hastings, Mindell, Browne & Barnsley, 1981) included 82 Directors of Public Health Nursing from across Canada in its mail survey. All of the Directors of Public Health Nursing surveyed were female (p. 17), 75% had been in the same job 5 years prior to the survey and 63% in the same job 10 years prior (p. 23), and 92% had a bachelor's degree or higher level educational qualification (p. 35). The Directors of Public Health Nursing ranked the following job skills in descending order based on the relative amount of time spent using the skill in their daily activities: listening, speaking individually with subordinates, writing briefs and memos, writing reports, reading mail, and meeting with groups (p. 57).

2.1.3.2 The Nature of Community Health Nursing

The nature of community health nursing poses problems and challenges for community health nursing managers. The mandate of community health services and community health nursing services is prevention. Although hospital nurses and physicians utilize prevention in their care of patients, most of the preventive effort is secondary prevention, prompt diagnosis and treatment to prevent or limit disability, and tertiary prevention or rehabilitation (ANA,

1980, p. 7; Leavell & Clark, 1965, chap. 2; Simmons & Stinson, 1980). In community health nursing the emphasis is on primary prevention; that is, on general health promotion and maintenance, health education, and specific illness prevention before illness has occurred (ANA, 1980, pp. 4, 7, 11; CPHA, 1977, p. 4; Leavell & Clark, 1965, chap. 2). Community health nursing is a synthesis of public health and nursing (ANA, 1980; Freeman, 1970, p. iii; Ruth & Partridge, 1978).

Hospital nurses, physicians and other primary care personnel typically focus on care of one individual client at a time (Ruth & Partridge, 1978; Williams, 1977); in fact, provision of individualized care (i.e., care adapted to the needs of the specific individual being served) is an important goal (Austin, 1974; Lamb, 1981), and Stevens (1978, p. 22) has noted that most theories of nursing are based on the one-to-one nurse-to-patient model. In community health nursing services, although many services are provided to individuals, the mandate is to serve groups or aggregates of clients and usually several or many aggregates at the same time; that is, a population-based service (Freeman, 1970, p. iii; Freeman & Holmes, 1960, p. 12; Ruth & Partridge, 1978; Williams, 1977).

The focus of community health nursing on serving aggregates of clients extends to the whole community, to continuing care throughout the life span, and to seeking clients who need care and are not receiving it, as opposed

to the typical focus of institutional nursing on episodic service to those clients who have sought care at a particular time (ANA, 1980, p. 2; CPHA, 1977, pp. 2-3; Freeman, 1970, pp. iii, 33; Simmons & Stinson, 1980; Williams, 1977; Ready, Note 10, pp. 9-10).

An historical development which has affected community health services in Canada has been the progressive change in the types and range of services provided. Originally public health services were focused only on communicable disease control, with a later emphasis on the establishment of services throughout the provinces so that services would be available to the total population. In 1940 the American Public Health Association listed the six public health services as follows: vital statistics collection, sanitation, communicable disease control, laboratory services, maternal-child health services, and health education. By 1971 a Canadian Public Health Association committee studying public health services listed thirty-one services, so that public health professionals were finding it increasingly difficult to meet the range of demands (CPHA, 1966a, 1977; Hanlon, 1969, pp. 10-11; Hastings, 1969; Schwenger, 1973; Morrison, Note 11).

The effectiveness of community health nursing services is very difficult to measure since many services have long-term effects, cause and effect are often difficult to establish, and many of the consequences are only apparent when the services are <u>not</u> effective (e.g., increased

communicable disease incidence as an indicator of poor sanitation or lack of immunization) (Engle & Barkauskas, 1979; Freeman & Holmes, 1960, pp. 11-12). The continuing nature of services and the focus on groups make it very difficult to define the "caseload" of a community health nurse or the community health nursing program. Thus, effectiveness and efficiency are not easily measured.

The type of services provided in community health demands a high level of judgement at the point where the service is being given (Freeman & Holmes, 1960, p. 10). The focus on continuity of service to clients and on seeking clients who need care mean that community health nurses are typically based in districts close to the population they serve; thus, in any health agency there are usually several suboffices where community health nurses are located. The director and supervisor are not in the same locations as the community health nurses, so that face-to-face contact with the majority of staff nurses does not usually occur more than once or twice per month.

2.1.4 Summary Regarding Nursing Management

Nursing management models can be considered as having a primary focus on one of five subjects: structure, process, content, the manager, or synthesis. Considerable emphasis has been placed on the process and content focus in nursing management models, and also on synthesis of focus. Very little nursing management literature focuses primarily on

the structure of management. Considerable literature related to the nursing manager focuses on leadership rather than management.

The role of the nursing manager received increased attention during the 1970s and early 1980s. New nursing management texts and journals were first published, and conferences for nursing managers were first held in the United States during the 1970s; Canadian conferences for nursing managers began in 1980. Studies of the nursing manager's role have found that the role was not clearly defined and role expectations were unclear. Directors of nursing who described their role seemed to emphasize being a leader, a facilitator, a manager and/or an educator; role conflict was a concern. Nursing educators discussed the nursing manager role primarily as a multiple role, and noted that role expectations were not consistently defined. Several references to Mintzberg's model of managerial roles were found in nursing management literature published since 1977, but only two studies were found which tested Mintzberg's model with nursing managers.

In a paper prepared for the Canadian Nurses' Association in 1981, Leatt stated:

> Very little is understood about the evolving roles of nurse administrators and the organization and management of nursing departments. In an area which blends two disciplines, nursing and management, it is a critical requirement to formulate theories and conduct research. To date, almost no research in Canada has focused upon this priority area. (p. 23)

At a 1976 conference Stevens, a nursing educator in the

United States, reported "it is accurate to claim a paucity of substantive research in nursing administration at the present time" (1978, p. 24). A practicing nurse administrator expressed the same concern in 1979 (McClure, p. 11). If these statements are true for nursing management as a whole, then there is an even greater need for research regarding community health nursing management and the role of the community health nursing manager. Very little literature was found which had a primary focus on community health nursing management. There would seem to be little question that a study of the administrative activities and behaviors of community health nursing managers would be timely, relevant and useful. Literature related to the methodology of this study will now be reviewed.

2.2 Literature Related to Methodology

The literature related to methodology is discussed in four sections: (1) Mintzberg's structured observation study of chief executives, (2) other structured observation studies of managers, (3) observational field studies, and (4) a summary.

2.2.1 Mintzberg's Structured Observation Study of Chief Executives

In order to study the activities, roles and programs of the work of chief executives in medium to large-sized

organizations (completed in 1967-68 as a doctoral study) Mintzberg developed a method which he termed "structured observation" (1970; 1973a, Appendix C). He stated that he developed the method because the purposes of the activities of managers had not been studied in detail and because managers were too busy with their work to be able to record their activities in such detail. Mintzberg chose a convenience sample of five chief executives, each of whom worked in a different type of organization in the United States (consulting firm, producer of industrial technological products, teaching hospital, producer of consumer goods, public school system). Each was observed by Mintzberg for five days, a total of 25 days of observation. Every managerial activity that occurred during those days was recorded chronologically along with data regarding the medium (type) of activity, the participants, the initiator, its major purpose, action taken, its location, and its duration in time (to the nearest tenth of an hour). These data were combined with preliminary data collected regarding the organization, the manager, and one month of the manager's scheduled meetings, and with anecdotal data which included more detail about specific activities of interest.

Considerable detail is given regarding the inductive analysis of the data which led to the findings about the characteristics of managerial work and the manager's working roles. The characteristics of managerial work described by Mintzberg (1971; 1973a, chap. 3) are the following: a great

quantity of work was performed at an unrelenting pace; activities were characterized by brevity, variety and fragmentation; the managers preferred live action (current, nonroutine activities); the managers strongly preferred the verbal media; the managers were the link between their organizations and a network of contacts; and the manager's job was a blend of rights and duties.

Ten managerial roles were developed by Mintzberg (1973a, chap. 4) as a result of considering the purposes of the manager's activities. The ten roles, which form three groups, interpersonal, informational, and decisional roles, are listed below.

1.	Interpersonal:	figurehead leader liaison
2.	Informational:	monitor disseminator spokesman
3.	Decisional:	entrepreneur disturbance handler resource allocator negotiator

Work differences among the five chief executives appeared to Mintzberg to indicate that the work of managers was influenced by the nature of the industry, the nature of the organization, the nature of the manager's style, and the needs of the moment (1973a, p. 264). Four issues in relation to structured observation as a method were discussed (pp. 268-277): difficulties in collecting certain kinds of data, unanticipated consequences due to the presence of an

observer, difficulties due to the pace of the work, and problems in coding.

The structured observation methodology Mintzberg developed has been reported in publications (1970; 1973a, Appendix C). The characteristics of managerial work and the managerial roles developed in Mintzberg's doctoral study along with recommendations regarding more effective management have been published in several articles (1971, 1973b, 1975b); the findings provide information which is part of the basis for discussion of management information (1972, 1975a) and of managers as planners (1976). The 1973 text The Nature of Managerial Work has been reprinted without revision, except for the deletion of the three appendices, as part of a series titled "The Theory of Management Policy" (1980). In discussing the reason for reprinting the book without other revisions, Mintzberg stated (1980, p. xv) that "it is still too early to consider making [significant changes] . . . . little else [regarding managerial work] has since been reported in the literature." In the texts the findings of Mintzberg's own empirical study are discussed in relation to a considerable volume of other (mainly empirical) literature regarding studies of managers' work. Characteristics of managerial work, the manager's work roles, variations in managers' work (a contingency theory), and science related to the manager's job (programming) are discussed in depth.

2.2.2 Other Structured Observation Studies of Managers

Reports were found of three Canadian studies in which structured observation was the method used to study managerial work. These studies will be discussed in chronological order according to the date they were completed.

2.2.2.1 Choran's Study of Small Company Managers

In a master's study completed under Mintzberg's supervision, Choran (Note 1) observed the work of managers of small companies using a methodology similar to that described by Mintzberg. His subjects were the owner-managers of businesses with a maximum of 250 employees, $1 million in assets, and $3 million in sales volume (chap. 1). The study subjects were a convenience sample of 3 owner-managers located in Montreal (companies were a manufacturer of industrial chemicals, a manufacturer of cosmetics and a restaurant, pp. 59-61). Each manager was observed for two days which gave a total of 6 days of data from structured observation. Data were recorded regarding the medium (type) of activity, its duration (to the nearest minute), the participants, the initiator, the location and the purpose of the activity (pp. 48-54, chap. 4).

Choran found that the characteristics of work of the managers he studied were similar to those recorded by Mintzberg: they performed a great quantity of work at an unrelenting pace; their work was characterized by variety,

discontinuity and brevity; they had a strong preference for current, specific and ad hoc activities and verbal media; they sat between their organizations and a network of contacts; and they controlled their own affairs. An additional characteristic of the work of small company managers was that they were involved with daily operational activities (pp. 124-133).

Choran stated that the managers he studied performed all of the roles outlined by Mintzberg, but that they also had two additional roles related to daily operations of their firms (pp. 133-136): specialist (e.g., inventory control, purchasing) and substitute operator (e.g., when employees are ill or leave the firm, or when there is a temporary need for additional manpower).

In comparing the results of his study with those of Mintzberg, Choran stated that the manager of small companies: had a higher number of activities, used the informal media more (telephone, unscheduled meetings, tours), had shorter scheduled meetings with fewer participants, had a greater proportion of activities with short duration, and received more mail from and sent more mail to subordinates and suppliers (chap. 5).

2.2.2.2 Duignan's Study of School Superintendents

Duignan (1979) did a doctoral study of the administrative behaviors of Alberta school superintendents using methodology developed from that reported by Mintzberg.

The school superintendent is the executive officer (usually the chief executive) of a school board. Duignan limited his study population to those school superintendents whose office was located within 150 miles of Edmonton, who had 100 or more teachers in their jurisdiction, and who were not within the Edmonton Public and Separate School Districts (chap. 1). He randomly selected two subjects from this population for his pilot study, and six other subjects for his main study. The pilot study subjects were observed for two days each and the subjects in the main study were observed for five days each (a total of 34 days of observation). Duignan collected data from the superintendent's diary for the week prior to observation, from his structured observation of the superintendents, and from a structured interview conducted with each superintendent. Data regarding administrative activities were recorded chronologically and included notes regarding the medium (type) of activity, its duration (to the nearest minute), the participants, initiator, location, decision outcome, and major purpose for the activity. The interviews were focused on determining the subject's perception of how closely his work behaviors corresponded to the managerial roles identified by Mintzberg (pp. 59-62, 66-70).

Duignan included both pilot study and main study results in his discussion of the findings; at times the difference between two days of findings from the pilot study and five days of findings from the main study becomes

distracting in studying the results. Duignan found that the school superintendents: were involved in numerous short-duration activities, had essentially discontinuous work which required dealing with many unrelated issues, spent a large proportion of time in verbal contacts, gathered and disseminated a large amount of information via verbal media, had pressures on organizing and controlling their time, had administrative behavior which was not as planned and organized as is suggested in the literature, had daily, weekly and seasonal patterns in their work, rarely made decisions on their own, and occupied a unique position which was seen as the "man-in-the-middle" (pp. 184-202). The ten roles described by Mintzberg seemed to describe about 70% of the administrative behaviors of Alberta school superintendents; about 27% of their time was involved in behaviors Duignan described as educational, in contrast to the executive behaviors described by Mintzberg (p. 183). Two subsequent articles (1980, 1981) summarize the findings of the study and the methodology respectively.

2.2.2.3 Hannah's Study of Deans of Nursing

In a doctoral study with methodology developed from that of Mintzberg and Duignan, Hannah (1981) studied the administrative behaviors of Canadian deans of nursing. The dean is the senior administrator of the academic unit within the university. Hannah limited her study population to deans of nursing in English-speaking Canadian universities which

offered generic nursing education programs. (At the time of her study there were 13 incumbent deans in these programs; chap. 1.) She randomly selected a sample of 5 (one each from the Atlantic, Quebec and Western regions and two from the Ontario region) which she planned to observe for two three-day periods separated by about six months. (One dean anticipated being unavailable for the total study so the regional alternate was used.) Thus, the design included 30 days of observation; 27 days of observation were completed. Preliminary data were collected regarding the deans and the settings within which the deans worked. The activities observed through the working day were recorded by Hannah in chronological order with data regarding the type of activity, the participants, the initiator, the location, the major purpose and the duration to the nearest minute. A structured interview held at the end of each observational visit provided data regarding the subject's perception of how closely her work corresponded to the roles identified by Mintzberg (pp. 60-65).

In considering purposes of activity Hannah found that deans of nursing performed all ten roles Mintzberg described, but in addition they had a group of roles which she termed scholarship behaviors: the behaviors related to those the dean performed as a teacher, researcher and author (chap. 5). Hannah found that the deans of nursing: had long work days filled with many activities of short duration and high intensity, preferred joint activities, had definite

seasonal variations in their administrative behaviors, had leadership behavior related mainly to faculty development, made few unaided decisions related to the faculty of nursing, had entrepreneurial activity related to finding alternative sources of funding to expand the faculty of nursing budget, focused on short-range rather than long-range planning, did not tour their domains, consciously committed themselves to scholarly behaviors, and were frequently torn between the interests of the faculty of nursing and the interests of the university as a whole (pp. 266-273).

2.2.3 Literature Related to Observational Field Studies

Literature related to observational field studies in general was reviewed to provide the researcher with further information regarding data collection and analysis. The review of such literature which is pertinent to this study is reported below.

2.2.3.1 Strengths and Limitations of Observational Field Studies

In field studies, observations of behavior are made in their natural settings, which is essential if the researcher believes that behavior is influenced by the setting or context in which it occurs (Davis, Kramer & Strauss, 1975, Preface; Pearsall, 1965; Swanson & Chenitz, 1982). Weick (1968, p. 362) states that "observational methodology is

typically used to watch persons in situations where they spend most of their time or in situations that at least are familiar to them."

The strengths of field studies are listed by Kerlinger (1973, p. 406) as: "realism, significance, strength of variables, theory orientation and heuristic quality." The realism contributes to external validity, because the more realistic the situation, the more valid are generalizations to other situations (p. 402). Williamson, Karp and Dalphin (1977, p. 209) state that the "essential strength [of a field study] is that it allows the researcher to continuously integrate the processes of data collection and analysis," an advantage which is also cited by Schatzman and Strauss (1973, p. 110).

The research instrument in an observational study is the observer himself; this is both the crucial strength and the crucial weakness of such studies. Kerlinger (1973, p. 538) states that "observation of human behavior requires competent knowledge of that behavior, and even of the meaning of the behavior," and that in field studies it is necessary for the observer to provide the link between the behavior which occurs and the construct which is recorded.

The weaknesses of field studies are listed by Kerlinger (1973, p. 408) as their "ex post facto" character, the "lack of precision in the measurement of field variables" due to the greater complexity of field situations, and potential weaknesses due to the practical problems of feasibility,

cost, sampling, and time. He also states that "usually [there is] so much noise in the communication channel that even though the effects may be strong and the variance great, it is not easy for the [researcher] to separate the variables" in the field situation (p. 407). The basic weakness of the observer is that he can make quite incorrect inferences from observations. The major criticism of field research according to Williamson et al. (1977, pp. 216-217) is that it "does not easily allow a researcher to produce reliable measurements of phenomena," and "there is no way to easily assess the reliability and validity of the interpretations made by the researcher." Six related weaknesses which were also listed by these authors (pp. 216-217) are: the small size of the social setting which can be examined; the lack of safeguards against the biases, attitudes and assumptions of the researcher; the potential of the researcher's selective perception and selective memory biasing the results of the study; uncertainty regarding the representativeness of the selected data; the influence of the observer on the situation being observed; and the limited replicability of field studies.

There are several measures which the researcher using an observational field study approach can use to offset some of these weaknesses. These will be discussed in the following sections.

2.2.3.2 Role of the Observer

Observer interference with the situation being observed can be minimized, according to Kerlinger (1973, p. 539), if the researcher is careful to be unobtrusive and to avoid giving the impression that judgments about actions are being made. Weick (1968, p. 375) noted that observers who made their aims explicit and who were known by the participants came to be accepted by the subjects as interested bystanders. Weick noted that this is particularly true of researchers "who study persons in familiar habitats" as these persons "soon forget that they are being watched or, if they do not, the observer will notice their concern" (p. 369). This tendency of the observed persons to forget about the observer has been explained by Schatzman and Strauss (1973, p. 58): "after all, their work and other pursuits are more important to them than merely impressing the researcher." Cunningham (1978, p. 106) and Field (1980, p. 460), who have used observation to study community health nurses' work, both concluded that the change occurring with the observer present was non-significant when the observer-nurse was a person who was acceptable (credible) to the nurses being observed.

Mintzberg (1973a, pp. 269-270) supported the view that the researcher's presence does not influence the work the manager does:

> The basic events of any manager's week are not subject to major change simply because a researcher is present. Scheduled meetings are set up well in advance, and incoming telephone calls and mail are not influenced by the presence of an observer . . . given the kinds of information to which I was exposed, there was no reason to believe that activities were delayed to avoid my being exposed to them.

The amount of observer interference can be affected by the role the observer takes in the study situation. The classification of observer roles commonly used is that of Gold (1958, p. 217) who listed four roles: complete observer, observer-as-participant, participant-as-observer, and complete participant. In both the complete observer and the complete participant roles the fact that observations are being made is not known to the subjects. The other two roles vary in the proportion of time spent in one or the other of the two roles. Schatzman and Strauss (1973, p. 59) note that the "relatively impassive observer . . . can be very disturbing to the hosts" and they recommend a "limited interaction" approach in which

> the researcher engages in minimal, clarifying interaction . . . . interventions . . . are confined mainly to seeking clarification and the meaning of ongoing events . . . . This type of activity has two distinct advantages: it gets at meaning, and it meets the expectations of the hosts insofar as the researcher is not only an observer, but is revealed as personable and interested.

Duignan (1979, p. 52) noted that the use of limited interaction helped to minimize the effects of his presence and thus to preserve the situation as close to normal as possible. Actions which were designed to minimize the effects of the observer's presence were noted by Duignan

(pp. 58-59) and by Hannah (1981, p. 75). As Weick noted "observers are often conspicuous because they play an unusual role, that of nonparticipant" (1968, p. 370). In the community health setting, Cunningham found that "minimal superficial participation interfered very little with nurse-patient interaction" (1978, p. 103).

2.2.3.3 Recording Observations

"The substance of systematic, objective, and analytical participant observation lies in keeping accurate and detailed field notes" (Williamson et al., 1977, p. 209). These authors recommended that the field researcher record the following types of observations: descriptions of the setting, the people, and the communications; statements of hunches or ideas about themes in the data; and methodological notes about the success or failure of the data-gathering approaches (pp. 210-213). In discussing numerous potential biases of the observer, Weick (1968, p. 432) observed that most of them involved memory, or the loss of alertness of the observer. It would seem that on-the-spot recording which is possible if the researcher adopts an explicit observer role would decrease the biases inherent in trying to remember data for later recording. Weick (p. 433) suggested that one way to deal with loss of alertness was to list several aspects of the situation which should be observed; that is, that some structure be used to assist in ensuring that at least those aspects are recorded. This

suggestion appears to have influenced Mintzberg in developing the methodology he called "structured observation" since he stated (1973a, pp. 227-228) that this method combines "the inductive power of observation . . . with the structure of systematic recording," thus enabling the researcher "to study systematically and comprehensively those parts of managerial work that are not well understood."

Three types of notes should be recorded according to Schatzman and Strauss: observational, theoretical, and methodological notes (1973, pp. 99-105). They also commented that the recording should be consistent with the type of observer role assumed, that it should contain more detail than is anticipated to be needed, and that the goal should be the maximum fullness of recording which is possible in the situation. Such recording is accomplished by use of a specimen record (Weick, 1968, pp. 416-417) or field log (McCall & Simmons, 1969, p. 74) which Weick notes has the advantages of face validity, permanence, extensive detail, continuity, and has behavior recorded "in situ."

2.2.3.4 Analysis of Data

The recording of theoretical or thematic notes while data are being collected can be thought of as a preliminary analysis (Schatzman & Strauss, 1973, p. 110) in which the researcher tries to make conceptual sense of the observed events.

Kerlinger (1973, p. 542) noted that the analysis of behaviors can proceed along two routes: the molecular approach, in which specific behavioral acts are analyzed (what Guest [1960, p. 225] termed the "deceptively simple classificatory question, who does what, with whom, when, and where?"); or the molar approach, in which broad categories of behavior are analyzed. The molecular approach has the advantage of high reliability because fewer demands are made for inference and judgment on the part of the researcher (Kerlinger, p. 543; Weick, p. 406). The molar approach requires a higher level of inference, and the greater the burden of interpretation put upon the observer, the greater the validity problem, but this does not mean that no burden of interpretation should be put upon the observer (Kerlinger, p. 539). This distinction between two approaches to analysis of behavior appears to be similar to the distinction made by Mintzberg (1973a, pp. 21-24) between the characteristics of managers' work (how long they work, with whom, and the type of activity involved), and the content of managers' work (the purpose of what they do; their functions or roles). It would seem that characteristics of work could be determined by a molecular approach, whereas a molar approach to analysis would be necessary to determine content of work.

In forming categories to describe molar-level behaviors (the purposes of activity in this study) Duignan (1979, pp. 81-82) recommended the constant comparative method of Glaser

(1965); in this method the researcher compares each new incident added to a category with the previous incidents coded in the same category, an iterative and developmental process. The need for inference in analysis of observational data was noted by Trow:

> The data gathered by participant observers are still data . . . . the data . . . are not a substitute for the interpretative inference. We all forget that at our peril. (1957, p. 35)

Descriptive statistical techniques, such as frequency distributions and graphs, measures of central tendency, and measures of variability are used to summarize and describe data thus facilitating understanding and interpretation of data about a known, measured group (Kerlinger, 1973, pp. 141-145; Welkowitz, Ewen & Cohen, 1976, pp. 15-16; Hazlett, Note 12). Frequency distributions and graphs describe all or nearly all of the data in a convenient way (Welkowitz et al., chap. 2). Kerlinger states that these two techniques should be used more in the behavioral sciences and argues that "distribution analysis may give a more complete picture of a phenomenon than other methods do" (p. 143).

Measures of central tendency, the mean, median and mode, summarize data by representing the average of a set of measures (Kerlinger, 1973, pp. 144-145) or by showing how the data are similar (Hazlett, Note 12). The mean (arithmetic average) has advantages which make it the most-used measure of central tendency in research using interval- and ratio-level data: it makes available the most

information by taking account of all the data, and it is the most stable of the measures of central tendency for most distributions found in practice. The influence of all the data on the mean makes it a relatively unstable or nonresistant measure if the data have a highly skewed distribution, and it cannot be used if the values of the extreme scores are not known. The median (the midmost measure or 50th percentile of a set of measures) is a more stable or resistant measure than the mean when the data are highly skewed or there are inexact data at the extremes of the distribution. The median is appropriate for use with ordinal-level data. If the measures are symmetrically distributed, the mean and the median will be the same or nearly the same value. If the researcher wishes to de-emphasize the extreme values in a set of data, the median is used rather than the mean. The mode (the value which occurs most often) is a descriptive measure used for nominal-level data, which ignores a substantial part of the data when used with data measured at a higher level. If the measures are normally distributed, the mean, median and mode will be the same value (Kerlinger, pp. 144-145; Kidder, 1981, pp. 317-319; Welkowitz et al., 1976, chap. 4; Williamson et al., 1977, pp. 406-410; Hazlett, Note 12). Kerlinger argues that it is useful to calculate medians and modes as well as means, because "multimodal distributions are signals of the possible operation of variables not taken into account" (p. 145).

Measures of variability which are commonly used include the range, the interquartile range, the standard deviation, and the variance. These measures indicate how much the values in a set of data differ from one another (Kerlinger, 1973, p. 145; Kidder, 1981, pp. 319-320; Welkowitz et al., 1976, chap. 5; Williamson et al., 1977, pp. 410-414; Hazlett, Note 12).

2.2.3.5 Reliability and Validity

A cautionary note made by Williamson et al. (1977, p. 218) is that those doing field studies be explicit about the procedural and analytical processes through which their data and interpretations are produced. Weick (1968, p. 366) noted that "greater deliberateness in the choice and arrangement of the observational setting can lead to sizable improvements in the precision and validity of observational studies." Stewart suggested that carefully-planned studies were needed which: (1) tried to isolate effects of the organization, job and personality on a manager's activities, and (2) held constant some of the variables affecting a manager's behavior (1968, p. 88). Holding constant some variables appears to be what Kerlinger (1973, p. 306) terms control of extraneous systematic variance, an important factor in research design. Mintzberg (1973, p. 130) noted that "the level of the job and the function supervised appear to account for more of the variation in managers' work than any other variables"; holding constant the level

and function would eliminate some of the systematic variance in managers' work.

Kerlinger (1973, pp. 538-539) suggested that faulty observer inference might be due to inadequate knowledge of that behavior and its meaning. This comment would seem to suggest that an observer with at least some knowledge of the situation(s) being observed is likely to produce a more valid description of that situation. Field (1980, p. 21), noted that the potential disadvantage of being a nurse studying nursing was the danger of overlooking data; as a safeguard against this danger she recommended a team approach to data gathering and analysis or at least discussions with non-nurses regarding the analysis (p. 467).

2.2.3.6 Ethical Dilemmas

Williamson et al. (1977, p. 206) maintain that ethical dilemmas tend to be more pronounced when the observer adopts a role which lies closer to the covert, participatory end of the spectrum of possible observational roles. They also maintain that "researchers must never deliberately misrepresent their identities to enter a private domain where they would otherwise have no legitimate access"; and they "must never misrepresent their research intentions."

2.2.4 Summary Regarding Methodology

Mintzberg developed a method he termed structured observation to study the work of chief executives in medium to large-sized United States organizations. The findings of his study and those of three Canadian studies in which structured observation was used to study managerial work were reported.

Literature related to observational field studies in general was reviewed to determine strengths and limitations of such studies and to obtain further guidance regarding data collection and analysis procedures. Observational field studies are used when the researcher wishes to observe both the behavior and the setting within which it occurs. Although there are limitations to observational field studies, most of them can be at least partly offset, according to the literature.

Observer interference can be minimized by an unobtrusive, non-judgemental observer, who is explicit about the research aims, who observes subjects in environments familiar to the subjects, and who engages in minimal interaction with the subjects. Incorrect observer inference and biased interpretations can be decreased by accurate and detailed records which are recorded on-the-spot, and by a recording system which imposes some structure on the recording process. Precision and validity of observational studies can be increased by deliberate choice of the observational setting so as to control extraneous systematic

variance. Explicit descriptions of the procedures used in data collection and analysis would enable better judgements regarding reliability and validity of the interpretations made, and would facilitate replication of the study.

2.3 Literature Related to the Setting for this Study

This study was related to the work of community health nursing managers in Alberta Local Health Authorities. Their work is undoubtedly affected by the setting or organization within which they work. The discussion of the organization of Alberta community health services begins with a summary of selected aspects of the historical development of such services in Alberta, and continues with a description of the current structure of the Alberta community health services system.

2.3.1 Historical Development of Alberta Community Health Services

When Alberta became a province in 1905, responsibility for all public health services was assigned to the Department of Agriculture. The first Public Health Act in Alberta, which became law in 1907, provided for creation of health districts throughout the province and for a local board of health in each district. In 1918 the Public Health Nursing Branch was established within the Department of the Provincial Secretary which then had responsibility for

public health. Alberta was the second province in Canada to establish a public health nursing service; a Director of Nursing and four graduate nurses formed the staff. Public health services were briefly the responsibility of the Department of Municipal Affairs, until in 1919 the Department of Public Health was created. Also in 1919 the Public Health Nurses Act was passed, and the first three District Nurses were hired to provide personal health services, including midwifery, in isolated areas of the province. The Department of Public Health continued to have responsibility for all health and welfare services as these were developed until the Department of Public Welfare was established in 1944 (Alberta, 1945; Bow & Cook, 1940; Somerville & Defries, 1959; Stewart, 1979; Morrison, Note 11; Ebert, Note 13).

The Department of Public Health continued to administer all health-related services and the Department of Public Welfare (later called Social Development or Social Services) all social welfare services until 1969. By that time the Alberta government was administering province-wide hospitalization insurance which had been introduced in 1958 and medical care insurance which had been introduced in 1969. From 1969 to 1978 there were several re-arrangements of responsibility utilizing government departments as well as commissions which were semi-independent of the government. Since 1978 there have been two government departments responsible for health matters. The arrangement

of responsibilities within these two departments at the time of this study was: (1) Alberta Hospitals and Medical Care had overall responsibility for active treatment hospitals including mental hospitals, long-term care in auxiliary hospitals and nursing homes, and medical care provided by physicians and selected other health personnel; and (2) Alberta Social Services and Community Health (ASSCH) had overall responsibility for community health services including community health nursing and home care, community mental health services, rehabilitation services and the full range of social services (AHMC, 1981; Annual reports, 1945 to 1979-80; ASSCH, 1979; ASSCH, 1981; Somerville & Defries, 1959).

The expanding scope of government health services can be seen. For 14 years after the province was formed, public health services were only part of a government department's responsibilities; then a separate Department of Public Health was formed which for 25 years administered all health and social services in the province. For nearly 40 years two government departments have administered the range of Alberta's health and social services.

Early public health services were totally funded by the provincial government; in 1923 a shared-cost formula was instituted with 50% provincial and 50% municipal provision of funds. This funding formula appeared to be a precursor to the development of public health units in local areas; an amendment to the Public Health Act allowing for the

development of local public health units was passed in 1929. The local public health units which were established after 1929 are called Local Health Authorities (LHAs), a significant name. The LHAs were, and still are, administered by Boards of elected representatives of the municipalities which form the particular LHA. From 1931 to 1973, municipalities provided from 25% to 40% of the funding for their programs, and except for a few statutory public health programs were free to spend their money as they saw fit. Provincial funding from 1956 to 1973 was based on a grant system, in which provincial grants were determined by the amounts provided by municipalities (municipality paid 40% and province paid 60% of total cost). This system led to extreme variation in programs among the "have" and "have not" areas of the province. In 1973 the provincial government took over 100% funding of the costs of provision of public health services. However, the administration of these services is maintained at the local level with consultation and technical advice available from the Health Services Division of ASSCH (ASSCH, 1979; Ebert, Note 13).

The first two full-time Health Units in Alberta were established in 1931, at Okotoks-High River and at Red Deer. Grants from the International Health Division of the Rockefeller Foundation covered 25% of the costs, the municipalities involved provided 25%, and the provincial government provided 50% of the funds needed. Gradually Health Units were formed in other areas of the province,

although the depression in the 1930s and the world war in the 1940s slowed this expansion considerably. In areas where no Health Unit or other medical or hospital facility existed, and the residents requested service, District Nurses were assigned by the provincial Department of Public Health. One unique service initiated by District Nurses and operated by the Department of Public Health during the summer months from 1924 to 1942 was the provincial travelling clinic. At these clinics in isolated areas medical and dental examinations, tonsil and adenoid and other minor operations, and dental treatment were provided. In 1945 the highest number of District Nurses, 36, was employed. A total of 63 District Nursing Stations were established over the years; as medical and hospital facilities became available and as Health Units were formed the District Nursing Stations were closed. Sixteen Health Units were formed during the 1950s and some of those previously formed expanded their area; by 1959, 92% of the province's population was served by 23 Local Health Authorities. The major areas left without locally administered services were the sparsely-populated northern areas; with the establishment of the High Level-Fort Vermilion and Fort McMurray Health Units in 1973 the total population of the province was covered by LHA services. Recently two Health Units amalgamated with other LHAs, so there are now 27 LHAs in Alberta, 25 Health Units and the Local Boards of Health in Edmonton and Calgary; only the

Worsley Municipal Nursing Station is still operating (ASSCH, 1979; Bow & Cook, 1940; Schartner, 1982; Somerville & Defries, 1959; Stewart, 1979: Morrison, Note 11; Ebert, Note 13).

2.3.2 Current Structure of Alberta Community Health Services

Responsibility for community health services in Alberta is shared between the Local Health Authorities (LHAs) who administer the services and the provincial department, Alberta Social Services and Community Health (ASSCH), which funds the services. The Minister of ASSCH and the Deputy Minister of the Health Services Division within ASSCH delegate the majority of the liaison work with the LHAs to the personnel within the Health Services Division who provide ongoing consultation to the LHA staff in their respective areas of expertise. One of the program units in the Health Services Division is the Community Health Nursing Unit which includes the Manager of Community Health Nursing and six Co-ordinators (ASSCH, 1979; Ebert, Note 13; Craig, Note 14).

Relatively few community health programs are prescribed by legislation, so there is considerable scope for these to vary across the province. The development of the LHAs as independent units and the emphasis placed on local autonomy have meant that operational policies and procedures for the implementation of programs were developed independently and at different times resulting in considerable program

variation among the LHAs. This program variation was a major reason why the government assumed 100% funding of local health services in 1973 (ASSCH, 1979; Schartner, 1982; Ebert, Note 13).

Since 1973 ongoing discussion regarding program development between the LHAs and the Department has been facilitated by a developing network of joint committees. These committees now include the Executive Review Committee (the executive of the Health Unit Association of Alberta and the Deputy Minister and other senior personnel of the Health Services Division, ASSCH), the Meeting of Directors of Local Health Authorities and Community Health Services (the 27 LHA Directors and several representatives of Health Services Division), and a number of standing subcommittees of the latter group which link LHA program directors with their respective consultants within Health Services Division. The Standing Committee on Community Health Nursing is one of these subcommittees; its membership consists of the Community Health Nursing Manager from each of the 27 LHAs, the Manager and Co-ordinators of Community Health Nursing, ASSCH, and the Nurse Epidemiologist, ASSCH (ASSCH, 1979; Schartner, 1982; Ebert, Note 13; Craig, Note 14).

Development of these committees had been preceded by the organization of societies, the first of which was the Society of Medical Officers of Health in Alberta formed in 1969. The LHA Boards formed the Health Unit Association of Alberta (HUAA); one of its roles has been to assist Boards

with negotiation of collective agreements. The Community Health Nursing Managers, Assistant and Regional Nursing Supervisors in the 27 LHAs and Nursing Consultants in the two Local Boards of Health in 1974 formed the Society of Community Health Nursing Supervisors of Alberta, a voluntary group with interests related to community health nursing management. The Alberta Community Health Nurses' Society focuses on nurses in community health; community health nursing managers may join if they wish. Other professional disciplines have also formed similar societies (Schartner, 1982; Craig, Note 14; Ready, Note 15).

Thus, the 27 LHAs (more detail regarding the observed LHAs will appear in Chapter 4) and the Health Services Division, ASSCH each form an organization. These 28 organizations, which are loosely-coupled by a network of committees and societies and other formal and informal relationships, form the current official community health services "system" in Alberta.

The LHAs are constituted under the provisions of the Health Unit Act and the Public Health Act (Alberta, 1980a, 1980b). Edmonton and Calgary, being cities with populations each exceeding 100,000, are Local Boards of Health formed within the provisions of the Public Health Act. The other twenty-five LHAs are constituted as Health Units under the provisions of the Health Unit Act (see Appendix A for a map of the LHAs). Local Boards of Health consist of one member of city council, the Medical Officer of Health, and eight

city residents appointed by city council. Health Unit Boards consist of municipal council members from the municipalities included in the Health Unit. All LHA Boards must appoint a Medical Officer of Health (MOH), who is to be the Director of the LHA and is to manage the LHA between meetings of the Board. The Health Unit Act provides that in Health Units the Supervisor of Nursing "shall assume the duties of the medical officer of the unit when the medical officer is not available" (Alberta, 1980a, p. 4). The majority of the LHA Directors are Medical Officers of Health, but there are currently eight Directors who are nurses (Docherty, Note 16). Reporting to the LHA Director is a community health nursing manager (called the Supervisor of Nursing, Director of Nursing, or Senior Nurse) who is responsible for provision of the community health nursing programs to the people in the LHA; some community health nursing managers have one or more assistants (called the Assistant Supervisor, Assistant or Associate Director, or Regional Supervisor).

Many community health nursing managers in Alberta LHAs have been long-term managers. According to the 1982 history Health Units of Alberta (Schartner) and Annual Reports of the LHAs (Note 17) there were at least twelve nurses, all from different LHAs, who had served as community health nursing managers for 15 or more years. Some of these community health nursing managers were in charge of community health nursing from the time the LHA was

established. Eight of these long-term community health nursing managers retired from their positions during the years from 1978 to 1982. Thus, within the past four or five years there have been numerous changes in the community health nursing management group throughout Alberta.

In 1982 the populations served by each LHA ranged from slightly less than 5000 (two LHAs) to more than 500,000 (Edmonton and Calgary); twenty-one LHAs served populations between approximately 26,000 and 135,000 persons. The majority of LHAs served populations which were geographically dispersed; all but three or four of the LHAs had staff located in one or more suboffices in addition to the main LHA office. Community health nursing staff ranged from 2 to about 130 per LHA in 1982; in the same twenty-one LHAs referred to previously, CHN staff ranged from 8 to 25 full-time nurses. In 1982 there were more than 600 community health nurses and approximately 65 community health nursing managers and assistants in the province (Ready, Note 15; ASSCH, Note 18; Yates, Note 19).

2.3.3 Summary Regarding Setting for the Study

The range of health services provided by the Alberta government has expanded from what was administered by one department which had other responsibilities to what now entails two full government departments to administer. Although the provincial government now provides 100% of the funds to provide local community health services,

administration of these services was maintained at the local level and local autonomy is considered to be very important. The first full-time Health Units in Alberta were established fifty years ago; two-thirds of the 27 LHAs now existing were established approximately 25 to 30 years ago. Considerable turnover of long-term community health nursing managers has occurred in the past five years. The populations served by Alberta LHAs range greatly in numbers. The current official community health services "system" in Alberta is formed of 28 loosely-coupled units (27 LHAs and ASSCH) which are linked by a network of formal and informal relationships. The majority of these links were formed in the past ten to twelve years and are facilitating a closer working relationship of these units.

2.4 Summary of Literature Review

Selected literature related to nursing management, to observational field studies, and to Alberta community health services has been reviewed in this chapter. The methodology actually used in this study to observe the work of Alberta community health nursing managers will now be reported.

3. METHODOLOGY

3.1 Research Design

The central objective in this study was to describe the activities and administrative behaviors of community health nursing managers. In order to achieve that objective, five related objectives were addressed. The objectives were:

1. to describe the structure of the organizations within which community health nursing managers work,
2. to classify the observed activities according to types and participants, and categorize the purposes of activity to derive administrative behaviors for four Alberta community health nursing managers,
3. to describe the similarities and differences among the observed activities and categorized administrative behaviors of the four Alberta community health nursing managers studied,
4. to develop a composite description of the activities and administrative behaviors of the community health nursing managers, and
5. to compare the composite description of the activities and administrative behaviors of the community health nursing managers with the composite descriptions of chief executives (Mintzberg, 1973a), managers of small companies (Choran, Note 1), Alberta school superintendents (Duignan, 1979), and Canadian deans of

nursing (Hannah, 1981).

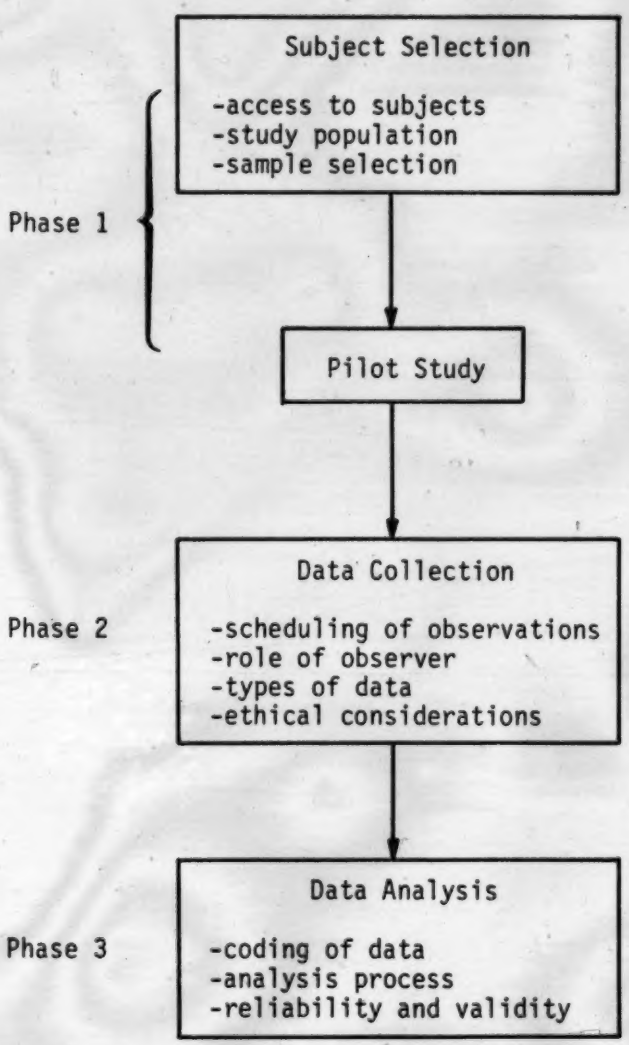
A field study approach was used because a description of the actual activities and administrative behaviors of community health nursing managers was desired. The primary method of data collection involved structured observation as described by Mintzberg (1973a), Duignan (1979), and Hannah (1981). The observational data were supplemented by data collected in interviews and from documents related to the organizations in which the community health nursing managers worked. The development of the methodology for this study was aided by review of selected literature (see Chapter 2) and by consultation with other researchers (Thesis Committee members, Friesen [Note 20] and Storch [Note 21]; Hannah [Note 22], and Craig [Note 23]).

The research design for this study involved the three phases which are shown in Figure 1. Although each phase is shown separately, data analysis began during data collection in the actual research process. The following discussion of methodology is organized in the sequence of the study phases.

3.2 Subject Selection

Figure 1

Research design phases



3.2.1 Access to Subjects

The population of interest for this study was community health nursing managers. Time and financial considerations imposed by the chosen methodology led to the decision to limit the sample to four managers. In order to compare similarities and differences among the observed activities and administrative behaviors of the community health nursing managers studied, limitations had to be placed on the study population. These limitations are designed to control some of what Kerlinger (1973, p. 306) terms extraneous systematic variance; that is, variation in what is measured or described that is not random and is outside the study objectives.

In Canada health care is the responsibility of the provinces, resulting in some variation of the health care system in the different provinces. In order to lessen the possibility of systematic differences, the community health nursing managers chosen for study were limited to those from one province; Alberta was chosen.

Since voluntary and official health agencies have somewhat different roles and structures, both of which may affect the activity and administrative behavior of managers, it was decided that only one type of agency would be used for this study. The organization delivering the official community health services was chosen; in Alberta, these are the twenty-seven Local Health Authorities which are funded by Alberta Social Services and Community Health (ASSCH).

When the proposed study was discussed with the then Director (now called Manager) of Community Health Nursing, ASSCH, she was confident that community health nursing managers in the Local Health Authorities would be sufficiently interested to be willing to participate. The Director of Community Health Nursing agreed to contact community health nursing managers to request their co-operation with the study after the study population had been carefully defined.

3.2.2 Study Population

The population of interest for this study was the "typical" community health nursing manager. Variation in activity and behavior among community health nursing managers was expected; however, in Alberta there were a number of factors which were expected to add so much variation that comparison of similarities and differences among the activities and administrative behaviors would not be meaningful. Investigation of the effects of these factors was beyond the scope of this study, but their potential influence was recognized and is discussed below. The definition of the study population that emerged as a result of consideration of these factors follows the discussion.

The number of nursing staff and the proportion of provincial population served by the twenty-seven Local Health Authorities (LHAs) in Alberta vary widely; four are very small and two are very large in comparison to the rest.

The community health nursing managers in the very small LHAs supervise functions other than community health nursing, and also provide some direct care. The community health nursing managers in the very large LHAs (Edmonton and Calgary) have a number of assistants as well as a level of supervisors between them and the community health nursing staff, thus they do not supervise staff nurses directly. Therefore, in order to limit the study population to managers supervising one function (community health nursing) and to managers at one level of the organization (those who directly supervise community health nurses), the community health nursing managers in the four very small and two very large LHAs were excluded from the study population.

A number of Alberta community health nursing managers had been appointed within the year prior to sample selection. It was considered likely that the community health nursing managers with less than one year's experience were still learning the manager's role, and that this role might change substantially as the manager became more experienced. Therefore, in order to study community health nursing managers and not beginning community health nursing managers, the persons with less than one year's experience as a community health nursing manager were excluded from the study population.

In some cases the community health nursing manager had assumed the duties of the LHA Director due to a vacancy during the past year in the LHA, or had themselves been

absent from their regular duties in the LHA for an extended period within the past year on educational leave. In these situations, because the community health nursing managers were assumed to be re-adapting to their managerial role as a result of the changes, it was possible that their roles at the time of sample selection were atypical and, therefore, they were excluded from the study population.

The community health nursing managers in LHAs which provide both community health nursing and primary care treatment services on a regular and continuing basis, may have somewhat different roles due to priority setting for primary care treatment services potentially being different from that for community health nursing programs. Only three of the twenty-seven LHAs provide primary care services on a continuing basis; therefore, their community health nursing managers were considered to be atypical, and they were excluded from the study population.

The community health nursing managers without a baccalaureate degree in nursing may have different activity and administrative behavior than those who do have a degree. It is more common for the community health nursing manager to have a baccalaureate degree, and since 1966 in Canada the recognized educational qualification for the community health nursing manager of small and medium-sized organizations has been a baccalaureate degree (CPHA, 1966). Therefore, those without a baccalaureate degree were considered atypical, and were excluded from the study

population.

Consideration of the expected variation in activity and administrative behavior, as a result of the factors discussed previously, led to the following definition of community health nursing manager used to define the population for this study:

> a baccalaureate-prepared nurse,
>
> who is currently employed full-time as a community health nursing manager in an Alberta LHA, exluding Edmonton and Calgary,
>
> who has held this job full-time on an uninterrupted basis for the past calendar year (at the time of selection),
>
> who is in an LHA which has ongoing community health nursing programs but no (primary care) treatment programs,
>
> who has an LHA Director who has been in the position for at least one year, and
>
> who is willing to participate in the study.

Inclusion of the criterion regarding willingness to participate in the study was not related to obtaining a "typical" community health nursing manager, but was necessary to include because the methodology required that the subject community health nursing managers be willing to have an observer with them for a period of time.

3.2.3 Sample Selection

Eight community health nursing managers met the criteria in the previously-listed definition of community health nursing manager; the number was low due to the

abnormally high turnover of community health nursing managers in the previous year (nine of the twenty-seven LHA managers had been appointed within the previous year).

The eight community health nursing managers who met the criteria were contacted by the Director of Community Health Nursing, ASSCH to obtain permission for their names to be given to the researcher (see letters in Appendices B.1 and B.2); all agreed to participate in the study when subsequently contacted by the researcher. (All of the community health nursing managers had contact with the researcher during a study conducted previously [Morrison, Note 24], and all had been told that she was a community health nurse.) When the population served and number of community health nursing staff were considered, the LHAs in which the eight community health nursing managers worked appeared to fall into two groups. One group had a large population and a large number of staff in comparison to the other. It was decided that two subjects would be selected from each group to yield the four subjects for the study.

Identification numbers of the LHAs in which the eight community health nursing managers work and a table of random numbers were used to choose the potential participants. The first two persons selected in each group were asked to be study subjects; the other two in each group were asked to be alternates in case a subject could not participate during the time scheduled for data collection. The subjects and the alternates were contacted by telephone; all eight agreed to

participate as necessary, and dates for observation were arranged. During the telephone contact the eight community health nursing managers were asked to send the researcher a copy of the most recent Annual Report for their LHA, the current organization chart for their LHA, and their personal resume if they had one available. The information received was used prior to actual observation to orient the researcher to the specific organizations in which the community health nursing managers worked and to the particular managers.

Letters confirming participation, as discussed by telephone, were sent to both study participants and alternates (Appendices B.3 and B.4). A brief description of the study was printed in the fall 1982 issue of the Community Health Nursing Bulletin so that all Alberta community health nursing managers would know about the study and would know how the study population had been selected (see Appendix B.5).

3.3 Pilot Study

In order to test the research design proposed for this study a pilot study was conducted. Two Alberta community health nursing managers who had not been included in the study population, because they did not meet all of the previously-specified criteria, were each observed for one day. These managers were selected for the pilot study in

order to keep a higher number of potential study subjects for random selection. The data collected from these two days of observation were analyzed in ways similar to those planned for the analysis of the study results. Findings were discussed with the community health nursing managers observed in the pilot study. Both managers had useful suggestions regarding the approach used in observation, explanations to subjects and the findings. As a result of the pilot study, data collection forms were modified slightly to include more detail regarding the context of the work situation. The findings of the pilot study were used to develop the study procedures; discussion of these is found in the following sections. Since the pilot study was used in this way, the findings are not included in the results reported in Chapter 4.

3.4 Data Collection

3.4.1 Scheduling of Observations

The pilot study for this project was conducted in August 1982. It was not possible to schedule observations during September due to the timing of other events which affected all Alberta community health nursing managers. Two modifications of the proposed schedule for observation occurred; all observations took place between October 1 and November 10, 1982.

Since the method of data collection involved intensive observation and detailed recording of data, the time period for observation needed to be relatively short. The one day per community health nursing manager utilized in the pilot study gave an indication of the proportions of time spent in the different types of activities, but was insufficient to give a good indication of the purposes of the activities. Similar studies have utilized periods of observation of two days (Choran, Note 1), three days (two three-day periods per manager, Hannah, 1981), and five days (Duignan, 1979; Mintzberg, 1973a). The total number of observation days for these studies were: 6 (Choran), 25 (Mintzberg), 27 (Hannah), and 34 (Duignan). Consideration of these doctoral dissertation studies (all except Choran's), and the scope of the master's thesis in comparison, led to the decision to use three-day periods of observation for this study for a total of 12 days of observation. Different days of the week were used with the different subjects, so that data from all working days of the week were collected.

3.4.2 Role of the Observer

Since the aim in data collection was to observe the regular work of the community health nursing managers in their usual working environment, the researcher used a non-participation, limited interaction approach to the role of observer. Thus, the researcher did not participate in the manager's activities; interaction which occurred is

discussed briefly below. The community health nursing managers in the study were informed regarding the process of observation, the types of data to be collected, and questions from them were answered as they occurred. The managers were encouraged to proceed with their regular work and to advise other staff members (especially nursing and clerical staff) to do so as well.

During the pilot study it was found that it was important to be seated in the subject's office so as to be visible to visitors only when they actually entered the office. Thus, the community health nursing manager could invite the visitors in and the presence of the observer would not interfere with the usual relationships. This was important because the community health nursing managers tended to work with an "open-door" policy, so that their staff had informal access to them. The researcher would greet those who came for meetings with the community health nursing manager, but after introductions and a brief comment about the purpose of the research, would return to an observational role and avoid participation. If comments were specifically addressed to the researcher, the researcher tried to make relatively brief comments to avoid changing the focus of the meeting.

At times, clarification of an event was required for purposes of the study; requests for such information were made to the community health nursing manager as soon as possible after the events occurred without causing undue

interruption. Such discussions were usually very brief.

3.4.3 Types of Data

As mentioned previously (see section 3.2.3) some preliminary information about each LHA and each subject manager was collected prior to the on-site observation period. This preliminary information was supplemented during the observation period by discussions with the community health nursing manager and by making notes about or obtaining copies of information about the LHA, and its programs and services. These anecdotal data, which related to the structure and context of the community health nursing manager's work, were recorded as opportunities occurred (e.g., during the community health nursing manager's desk work sessions).

The second type of data collected on-site was the structured observation data in which were recorded all of the community health nursing manager's activities throughout each working day during the three-day period. Three forms (see Appendices C.1, C.2, C.3) facilitated the recording of these data:

1. the chronological observational record, on which the time of each activity (to the nearest minute) was recorded as it occurred, whether or not the activity was previously scheduled, where it took place, participants in the activity (if any), who initiated the activity, the type of activity, and its purpose;

2. the mail record, on which was recorded a code to cross-reference the item to the observational record, the source of the item, the title of the correspondent, the type of mail item, its purpose, and the action taken as a result (if any);
3. the telephone record, on which was recorded a cross-reference code, the initiator of the telephone call, the title of the other participant, the purpose of the call, and the resulting action due to the call (if any).

An interview was held with each community health nursing manager on the third day of observation to discuss with her how "typical" the three days had been of her usual work, and how the method used for data collection had affected her work. Notes were taken during these interviews. A list of the interview questions is found in Appendix C.4.

At the conclusion of the observation period each study subject and pilot study subject was sent a letter thanking her for her participation in the study, and each alternate was sent a letter thanking her for her willingness to participate (Appendices B.6 and B.7).

3.4.4 Ethical Considerations

The researcher openly discussed the study with the participants, and the types of data collected were known to them. The subjects all gave informed consent to participation in the study. Thus, the ethical conflict of

observing persons who do not know they are being observed was avoided.

Occasionally during the observational period there was a meeting in which either the subject or the other person(s) involved did not wish to be observed; as had been agreed, the researcher withdrew immediately upon such occasions. Only very brief information was required about such meetings; the title or position of the participants, the duration of the contact, and its primary purpose. The procedure for dealing with such situations had been discussed with the community health nursing manager on the first morning of observation. These situations occurred on only four of the twelve days of observation and in total were less than five percent of the observed time. Some mail received by subjects was viewed by the researcher in order to gain the data for the study; most mail was not seen. In the latter case, the subject summarized briefly the data needed for the study (i.e., position of correspondent, type of item, purpose and nature of the action resulting).

The subjects were assured that information obtained during the observation period would be known only to the researcher, and was to be used only for this study unless permission for release of information was requested from and given by the subjects. Further, subjects' identity would be known only to the researcher and would not be reported, and results of the study would not be reported or discussed in ways that would enable identification of the individuals who

had a particular profile of activities or behaviors.

3.5 Data Analysis

3.5.1 Coding of Data

The observational notes were coded so that each activity could be identified separately. Decisions regarding when an activity begins or ends are not easy; however, the guidance of previous studies was helpful, and Duignan's definition of the "administrative activity" was used:

> An administrative activity was defined as a single event with an identity of its own. It had an observable beginning and ending in a time continuum. It ended when a major change occurred in one of the elements or dimensions of the (community health nursing manager's) behavior, e.g., when there was a change in the basic participants and/or medium of communication (1979, p. 64).

The definitions of the following terms used for coding the types of activities were adopted from Duignan (1979, p. 64-65); the only changes in wording made for this study are enclosed in parentheses.

> Unscheduled meetings. These referred to meetings between the (community health nursing manager) and others that took place by chance, on the spur-of-the-moment, or with less than 30 minutes notice.
>
> Scheduled meetings. These consisted of meetings between the (community health nursing manager) and others that were arranged at least 30 minutes prior to their occurrence.
>
> Desk work. This refers to the times that the (community health nursing manager) worked at (her) desk, processing mail, writing letters and reports,

and reflecting on events.

Telephone calls. These included both incoming and outgoing telephone calls. Any calls placed by the (community health nursing manager) that were not completed, for whatever reason, were included.

Travel. This included travel by the (community health nursing manager) to various (parts of the LHA) during (her) working day, as well as travel to evening meetings.

Tours and visits. These refer to the time spent by the (community health nursing manager) in various parts of (the LHA) for the purpose of (1) observing general aspects of the system's operation, and (2) observing (staff members) for evaluation.

3.5.2 Analysis Process

The data analysis began in the observational setting with the recording of "thematic" notes which the researcher made regarding interpretations of activities or groups of activities. After leaving the observational settings, the daily observational notes were typed and then divided into units of activity according to the definition presented previously. The process used for the preliminary analysis was that of Hannah (1981, p. 68-69): each unit of activity was assigned a unique code number, and the coded observational record was cross-referenced to the mail and telephone records (see Appendices C.1, C.2, C.3 for examples). Copies were made of all coded records. One master copy was kept intact; the other was cut into individual units.

Two levels of analysis were used in considering the data collected from observation. The first was what

Kerlinger (see section 2.2.3.4) termed the molecular-level analysis in which specific behavioral acts were analyzed; in further discussion in this study these acts are called activities. Activities were analyzed according to type and participants. The second level of analysis was Kerlinger's molar-level analysis in which broad categories of behavior were analyzed; in further discussion in this study these broad categories are called behaviors. The behaviors were derived by categorizing activities according to their purpose.

The data notes of individual activity units were first sorted according to the type of activity; the types were described previously in the section on coding of data. Total time and total numbers of activities were then recorded on a daily summary sheet (Appendix C.5). In order to permit comparison of the summarized data, all totals were converted to percentages of the entire day's time and activity.

The data notes were sorted a second time according to the participants in the activities, and the totals for time and number of activities were recorded on the summary sheet. Participants in the community health nursing manager's activities were divided into those from within the LHA and those from outside the LHA. Those within the LHA included the community health nursing manager's superordinates (Medical Officer of Health, Board members), subordinates (assistant who acted as a "deputy director of nursing", community health nurses), peers (directors of other

departments), and all other persons in the LHA. Those outside the LHA included persons from other LHAs, from the government, from other organizations, and from the public.

The third sorting of the data notes was according to the purposes of activity, which enabled categorization of behaviors. The categories used for these purposes were developed from the data collected in this study. As themes became apparent, information was categorized and re-categorized according to the constant comparative method discussed by Duignan (1979, see section 2.2.3). Since the categories of purpose were developed from the data in this study they will be reported in Chapter 4. Three sets of results corresponding to the three sortings of the data notes within the two levels of analysis will be reported in Chapter 4.

3.5.3 Reliability and Validity of Observational Data

During the field observation the structured observation methods adapted from Mintzberg (1973a), Duignan (1979), and Hannah (1981) were used; use of these established recording and coding procedures provided assurance of reasonable reliability. Measurement of interrater reliability was not attempted because only the researcher observed the subjects. Efforts were made to maximize intrarater reliability by: testing and refining the skills needed by the researcher in the pilot observations of two managers; by carefully defining the terms used for recording and coding; by

checking perceptions of events with subjects; and by maintaining, as much as possible, an objective approach to observations.

The researcher attempted to minimize the observer effect on validity of observations by: providing information about the study before the subjects consented to participate, protecting the anonymity of the subjects, briefing the subjects at the beginning of observations, maintaining an unobtrusive, non-judgmental presence, and using a cooperative approach with subjects. Interviews were held with each subject in order to check how valid the observations were in terms of recording the "typical" or usual work of the community health nursing manager. Observer interference with validity was lessened because the subjects saw the researcher as a colleague who would not be as judgmental as they thought an observer would be who was not a community health nurse. The categories of behaviors were discussed with two non-nurses to try to decrease the potential bias which could occur since the researcher was a nurse studying nursing. Validity was also enhanced by the use of many items of evidence to develop the categories of activities and behaviors so that interpretation of them could be made with greater confidence.

3.6 Summary

The research design for this study was discussed in relation to the phases of subject selection and the pilot study, data collection, and data analysis. Results of these procedures will be presented and discussed in the following chapter.

4. PRESENTATION AND DISCUSSION OF RESULTS

The results of this study are presented and discussed in three major sections: (1) a description of the organizations within which the four observed community health nursing managers worked, (2) an analysis of the observational records obtained for four Alberta community health nursing managers, and (3) a comparison of the findings regarding community health nursing managers with the findings of other structured observation studies of managers.

4.1 Structure of Observed Organizations

The overview of Alberta community health services in Chapter 2 (section 2.3) provides background information necessary to an understanding of the description of the observed Health Units. Historically, the range of health and welfare services provided by the Alberta government has expanded from what could be administered by one department which had other responsibilities to what now entails two full government departments to administer. Alberta Local Health Authorities (LHAs) have developed as autonomous units, although for the past ten years they have been totally funded by the provincial government. Alberta LHAs vary considerably in the size of population served, and in the resources available to meet the needs of the population.

The above description briefly summarizes the context within which Alberta Health Units exist. The Health Units and the community health nursing units within which the observed community health nursing managers worked are described in the next two subsections of this chapter.

4.1.1 Structure of the Observed Health Units

The Health Unit Boards in the four observed Health Units were composed of elected municipal councillors, as stipulated by the Health Unit Act. In each Health Unit the Director of Administration or Administrative Officer was also Secretary to the Board. These four Health Units each had a Medical Officer of Health as Director; as noted previously (section 2.3.2) two-thirds of Alberta LHAs currently have a Medical Officer of Health as Director. Board meetings were generally held once a month. In two of the Health Units the community health nursing manager attended all Board meetings (along with the Medical Officer of Health and the Director of Administration); in two Health Units the community health nursing manager attended fairly regularly but not every meeting or not for the total meeting.

The four Medical Officers of Health all had educational qualifications pertinent to their position (e.g., Diploma in Public Health or Diploma in Health Administration) in addition to their medical degree. Two of the Medical Officers of Health had experience working in government

health departments prior to becoming Medical Officer of Health. Two of the Medical Officers of Health had been in their Health Unit for less than 5 years; two had been in their current position more than 10 years.

Selected comparisons of the four observed Health Units are listed in Table 2. Two of the Health Units were predominantly urban and had a larger total population in comparison to the other two which were predominantly rural, had a smaller total population to serve, and a smaller total staff. All four Health Units included a variety of groups in the population whose special needs had to be considered in providing service: for example, urban and rural groups; predominant age groupings in a district (e.g., families with young children, persons over age 65); ethnic/religious backgrounds (e.g., Indian, Metis, Hutterite, Indochinese refugees).

A typical organization chart of a Health Unit is shown in Figure 2. Minor variations in lines of authority occurred from one Health Unit to another, mostly because the number of staff members in each program area varied, but the organizational structure was very similar in all four Health Units. Program Directors' meetings were held monthly in two Health Units; in the other two they were held occasionally or not at all. Every one of the four community health nursing managers stated that a lack of sufficient support staff hampered effective utilization of community health nursing staff.

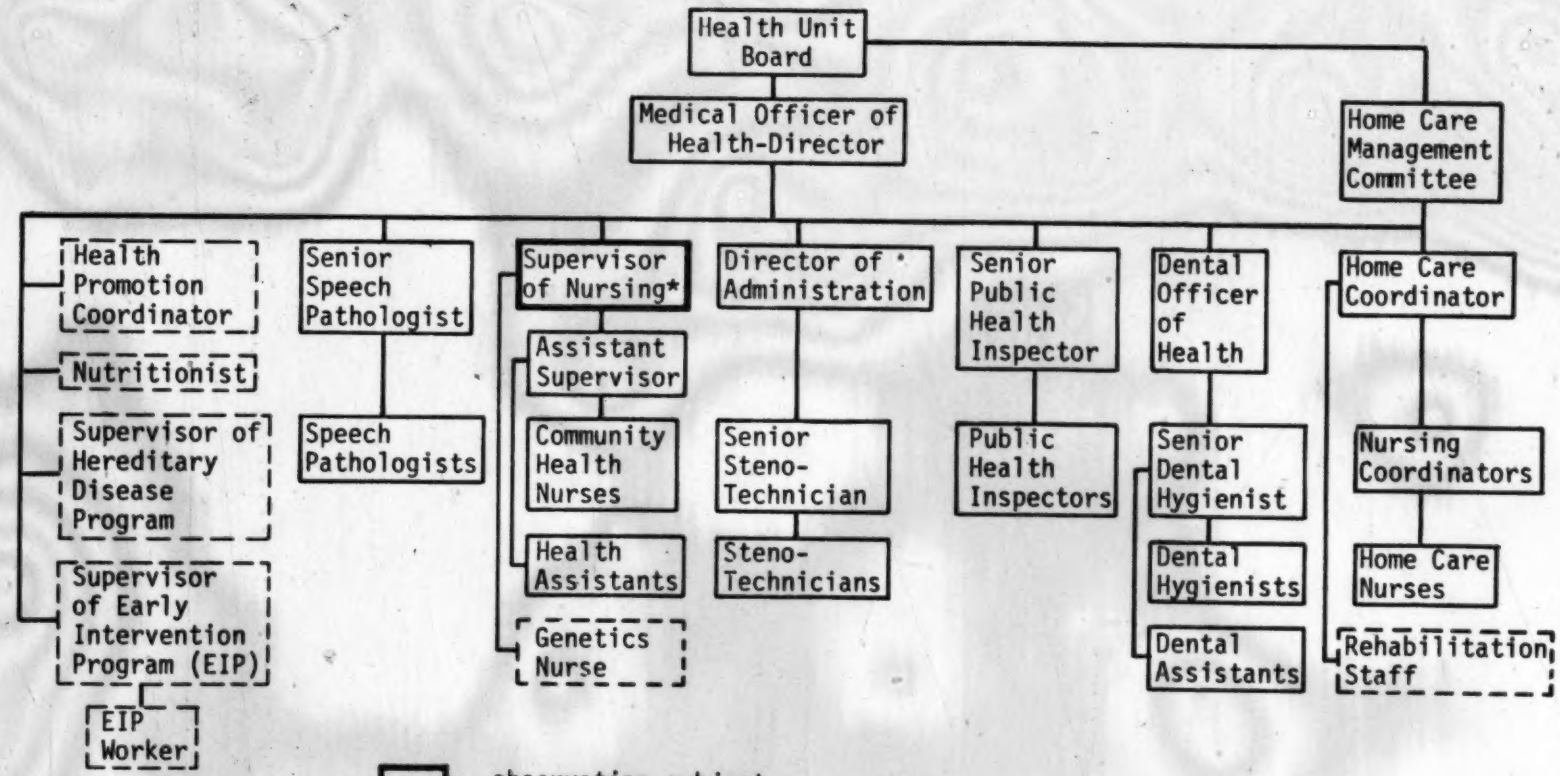
Table 2

Selected Comparisons of the Four Alberta Health Units Studied

Category of Comparison	Comparison
Population served by Health Unit in 1981	30,000 - 85,000
Geographic area of Health Unit	3500 - 9500 square miles
Size of urban centers within Health Unit	2 Health Units contained one large city (population over 25,000); in 2 Health Units no urban center had a population over 10,000
Proportion of Health Unit population considered rural	35 - 40% in 3 Health Units; one had a much smaller proportion
Number of suboffices in Health Unit	3 - 5
Total staff of Health Unit	35 - 80 persons
Community Health Nursing staff as proportion of total Health Unit staff	at least one-third

Figure 2

Typical Organization Chart of a Health Unit



All of the Health Units located some staff in suboffices. Each suboffice had at least one community health nurse located there; in some suboffices the community health nurse(s) and a part-time clerical person were the only staff permanently located in the suboffice. Staff of other programs travelled to these districts from the main office or a larger suboffice.

In all four of the Health Units a move to a new building had occurred recently or was being planned. In one Health Unit the community health nursing manager had a major involvement in the plans for new space; in the other three there was significantly less involvement.

Two of the Health Units had collective agreements between the Board and a union which represented the staff nurses; one Health Unit had a collective agreement between the Board and a staff association which was not a union; one Health Unit had no collective agreement between the Board and staff members (conditions of employment were included in the letter offering employment and the individual had to accept these conditions in writing before being officially hired). In the two Health Units with unions of nurses, the community health nursing manager had been part of the management team negotiating the collective agreement for nurses.

Formal documentation of policies and procedures varied considerably in the Health Units observed. In two Health Units there was a manual of personnel policies; in the other

two Health Units the only written personnel policies were in the staff-Board agreements. Hiring of new staff members was officially the responsibility of the Board in all four Health Units. Two Health Units had definite procedures for hiring new staff; applications were screened, a panel interviewed prospective employees, and a joint decision was reached regarding the most suitable applicant. The other two Health Units did not have procedures which were as well-defined.

An annual report of Health Unit activities was regularly prepared in two of the Health Units; in the other two no such report had been prepared since 1978. Formal reports to the Board were presented by each Program Director every two to three months in three of the Health Units.

4.1.2 Structure of the Observed Community Health Nursing Units

The four community health nursing managers reported directly to the Medical Officer of Health and through him to the Health Unit Board (see Figure 2). In two Health Units the Medical Officer of Health regularly delegated considerable responsibility to the community health nursing manager and expected considerable input into overall Health Unit administration. Conversely, in the other two Health Units very little responsibility for overall Health Unit administration was delegated to the community health nursing manager (e.g., planning for new Health Unit buildings,

communication with organizations outside the Health Unit). In all four Health Units the policy of the community health nursing manager assuming the duties of the Medical Officer of Health in his absence was clearly stated and followed.

Two of the four community health nursing managers had been in their current positions as Supervisor (Director) of Nursing in the Health Unit for less than 5 years; two for more than 8 years. Total community health nursing experience of these managers ranged from 7 to 25 years. All had a baccalaureate degree in nursing (those without a baccalaureate degree had been excluded from the study). All had experience in a supervisory or administrative role in community health nursing prior to their current appointment. All had nursing experience in some other part of Canada in addition to Alberta; two had nursing experience in a country other than Canada.

One community health nursing manager did not have an Assistant, one had one Assistant, and two had two Assistants who shared the responsibility for the community health nursing staff and programs. The number of community health staff nurse positions in the four Health Units ranged from 9.5 to 20; the number of community health assistant positions ranged from none to 5.5. All Health Units had some part-time staff who shared the community health nursing and community health assistant positions so that the total number of persons supervised by the community health nursing manager ranged from 11 to 29. In three of the Health Units

the proportion of part-time staff was 25% or less; in one Health Unit nearly one-half of the community health nursing staff worked part-time. All community health nursing managers expressed concern about the added supervisory workload created by part-time staff, because of the increased number of different staff members who must be considered in relation to orientation, inservice education, supervision and evaluation. This concern led two of the community health nursing managers to limit the number of part-time positions, and to require that they be job-sharing positions in which two half-time community health nurses share one district so fewer extra demands are placed on the full-time community health nurses.

None of the community health nursing managers directly supervised any staff other than community health nurses or community health assistants, except in two Health Units the Hereditary Disease Program Nurse was supervised by the community health nursing manager. The community health assistants, who are persons trained on-the-job or in a community health representative course at Alberta Vocational Center, performed specific tasks under the supervision of the community health nurses. The Hereditary Disease Program Nurses had a specialist function (usually combined with another specialist function). Two Health Units had part-time staff who did prenatal class teaching only. All other community health nurses were responsible for generalized community health nursing programs in a designated district.

Some community health nurses developed specific expertise due to interest and/or the type of caseload or district they served; often they were assigned more responsibility in an area of expertise (e.g., increased caseload of that type, committee work, development of inservice education program for other community health nursing staff).

In two of the Health Units almost all community health nurses had a baccalaureate degree in nursing; in the other two Health Units about one-half of the community health nursing staff were Registered Nurses without community health nursing educational preparation. The staff nurses' experience in community health nursing varied from very little (for the majority of newly-hired staff) to more than 10 years. Most of the community health staff nurses were relatively stable in their positions, although all Health Units had some regular turnover of staff.

Staff nurses' meetings were usually held about once per month in all four Health Units. In some Health Units inservice education sessions were held in alternate months to staff meetings for planning and discussion; in others both inservice education and planning occurred each month with the proportion of time varying as required.

Formal documentation of policies and procedures related to community health nursing programs varied in the Health Units observed. There were written job descriptions for community health nursing manager, community health nursing staff and community health assistant positions in all four

Health Units. A Program Manual with descriptions of programs and guidelines regarding implementation of the programs (including necessary procedures) was available in two Health Units; the other two were in the process of developing such a manual. Written goals and objectives for nursing programs were not explicitly stated in any of the Health Units; in two Health Units development of specific written objectives for each program was a current project. One or more Health Units had well-organized manuals for orientation of community health nurses, immunization schedules and procedures, and prenatal class teaching guidelines and resources. In all Health Units there was resource material available in each of the areas mentioned above, but it was not always organized as a single source which would facilitate its use as a reference. The nature of community health nursing service, the majority of which is delivered by individual staff members at locations away from any possibility of direct supervision (e.g., client's homes, schools and other agencies, suboffices), increases the need for up-to-date resources which can be readily referred to by staff members at times and places appropriate to them. All four community health nursing managers stated that maintaining up-to-date manuals and up-to-date written documentation of policies and procedures is a continuing problem for them. The two with longer tenure in the Health Unit seemed to have more of this material up-to-date than those with shorter tenure.

A concern expressed by three of the four community health nursing managers related to the poor or non-existent orientation they had received to their jobs as community health nursing managers. They expressed a need for more assistance for new community health nursing managers, and for themselves in developing their roles as managers. This would seem to be a pertinent need since there were nine community health nursing managers in Alberta who had been in their positions for less than one year when the sample for this study was being chosen.

The documented position descriptions of the four community health nursing managers showed considerable similarity despite having been developed independently. The qualifications specified for and the position summaries of the Director/Supervisor of Community Health Nursing in the four observed Health Units are compared in Table 3. The types of qualifications listed in all the position description documents were the same (education, professional registration, experience, skill), but there was variation in the specified requirement within each type of qualification. Education requirements specified nursing education only; formal management education was not specified as a requirement. (Stinson, 1978, noted that administrative preparation is part of many, but not all, baccalaureate nursing curricula in Canada.) Experience required or preferred related to both community health nursing and management.

Table 3

Comparison of Qualifications for and Position Summaries of Community Health Nursing Managers as Listed in Position Description Documents of the Four Alberta Health Units Studied

Category	Comparison
QUALIFICATIONS:	
-baccalaureate degree in nursing	-required in two Health Units; preferred in the other two
-registration in Alberta Association of Registered Nurses	-active registration required in two Health Units; "eligible for registration" specified in the other two
-three or more years recent experience in community health nursing	-three Health Units; the fourth specified a minimum of two years
-previous experience in administrative, supervisory or leadership position	-all four Health Units preferred some experience of this type
-evidence of interpersonal relationship skills	-three Health Units; the fourth did not specify this type of skill
POSITION SUMMARIES: The Community Health Nursing Manager:	
-is responsible to the Medical Officer of Health	-all four Health Units
-is responsible for the overall planning, directing, organizing, co-ordinating, evaluating, implementing and controlling of the community health nursing program	-three Health Units; the fourth did not include a general statement of this type
-promotes the quality of community health nursing services	-three Health Units; the fourth did not state "promote quality", although "evaluating effectiveness" is stated
-assumes the duties of the Medical Officer of Health in his/her absence	-all four Health Units

In comparing the duties and responsibilities as listed in the four position description documents, a total of thirty-one separate items were found in these documents. The sixteen duties and responsibilities which were common to three or four of the position descriptions are listed in Table 4.

In summary, the community health nursing manager's positions were very similar in all four Health Units in terms of who her superordinates, subordinates and peers were and the responsibilities she had for the community health nursing programs. There was considerable variation in her responsibilities as part of the management team of the Health Unit, the assistance she had in carrying out her responsibilities, and in the numbers and educational preparation of her subordinates.

4.2 Results and Analysis of Observations of Four Alberta Community Health Nursing Managers

The results of this study of the activities and administrative behaviors of four Alberta community health nursing managers are presented and discussed in three sections: (1) types of activity, (2) participants in activity, and (3) purposes of activity (administrative behaviors). Data for this section were obtained from the observation records kept by the researcher and from the notes taken as a result of discussions with the subjects.

Table 4: Duties and Responsibilities of Community Health Nursing Managers

1. Establishes community health nursing program objectives and standards in accord with Health Unit philosophy.
2. Participates in management decision-making process as it relates to community health nursing (personnel policy, job content, quality control standards).
3. Recruits, interviews and recommends appointment of nursing personnel.
4. Co-ordinates the cost-effective utilization of community health nursing staff (staffing requirements and patterns, re-assignment of personnel).
5. Evaluates staff performance in consultation with Regional/Assistant Supervisor; initiates corrective or disciplinary action as appropriate.
6. Participates in development of in-service education for staff development.
7. Assesses community health needs; plans, implements and evaluates effectiveness of community health nursing programs in meeting those needs.
8. Prepares community health nursing budget.
9. Collaborates with community agencies and groups to promote and maintain a high standard of community health care.
10. Ensures that physical facilities, supplies and equipment are adequate to efficiently carry out nursing programs.
11. Ensures proper and economical use of equipment, supplies and facilities.
12. Maintains community health nursing records.
13. Prepares Health Unit reports as required (Annual Report, reports to Board).
14. Develops and updates policies, procedures and manuals.
15. Plans with educational institutions to provide field experience for students in health-oriented disciplines.
16. Participates in special studies and research programs (initiates, participates in and utilizes research).

The four community health nursing managers were each observed for three working days. The numbers of activities performed and the times taken up by activity and behavior are presented in the following sections in terms of averages per day; that is, the mean value of the three days. Use of these average values as indicators of what these community health nursing managers do was considered to be a better representation of overall activity than the day-by-day values would have been. In all cases a mean value for the four community health nursing managers is presented as well; these mean values represent an average per day for all managers and were calculated by taking the mean value of the total twelve days.

Both the mean and the median were calculated for the data regarding the community health nursing managers. Although not all values were exactly the same, there was not a significant difference in any of the values. The researcher had no reason to de-emphasize any of the values (as there was no reason to conclude that any of the community health nursing managers had more appropriate results than any other), and since there were only four cases, measures which utilized all the data were used. Therefore, the mean is reported in the following discussions, and the distribution of results is shown graphically. Significant modal distributions (e.g., bimodal distribution) and significant variability of results are discussed using the graphs as a basis for discussion. Only

these two statistical descriptions, the mean and the distribution as shown in bar graphs, are reported as the researcher did not want to report more types of descriptive statistics than there were cases.

The following discussion emphasizes proportion of time as an indicator of the relative importance of the various types and purposes of activity. The detailed data regarding actual time spent on activities and behaviors are included in Appendix D.

4.2.1 Types of Activity

The community health nursing managers who were observed had average working days of from 7.1 to 8.3 hours, with a mean overall value of 7.6 hours. This time represents total working time for the day and does not include the lunch break. The two community health nursing managers with the 7.1 and 7.2 hour days stated that they have made conscious efforts to control the amount of time they work; community health nursing manager 3, who had the longest average day, stated that she has a personal goal to cut down the overtime she works to an average of two hours per week within the next six months. The four community health nursing managers stated that they had put limits on the type of work-related tasks they did at home; all did the majority of their professional reading at home, a considerable amount of travel time to out-of-town meetings was scheduled for after-work time, and planning activities were frequently

done at home because there were fewer interruptions.

The first analysis of the community health nursing manager's activities was in relation to the type of activity. Seven categories were used for type of activity (definitions were given in Chapter 3): desk work, telephone calls, scheduled meetings, unscheduled meetings, tours, and travel. A category of unclassified activity included interactions with clerical staff or brief personal activities. The proportions of working time spent in these types of activity are shown in Table 5 and Figure 3. (The actual times spent in each category are listed in Appendix D.1.)

It can be seen that desk work and scheduled meetings take up the largest proportions of time when the mean values are considered and that one or the other is the first-ranking use of time for all four community health nursing managers. It can also be seen that these two types of activity tended to offset one another. Community health nursing managers 1 and 3 had nearly twice the proportion of desk work time that community health nursing managers 2 and 4 had; the reverse is true when scheduled meetings are considered. This finding is further verified by the responses of the community health nursing managers to the question: "What activities are you typically involved in that I have not observed?" The first such activity mentioned by community health nursing manager 1 was scheduled meetings, and she listed a considerable number of scheduled

Table 5

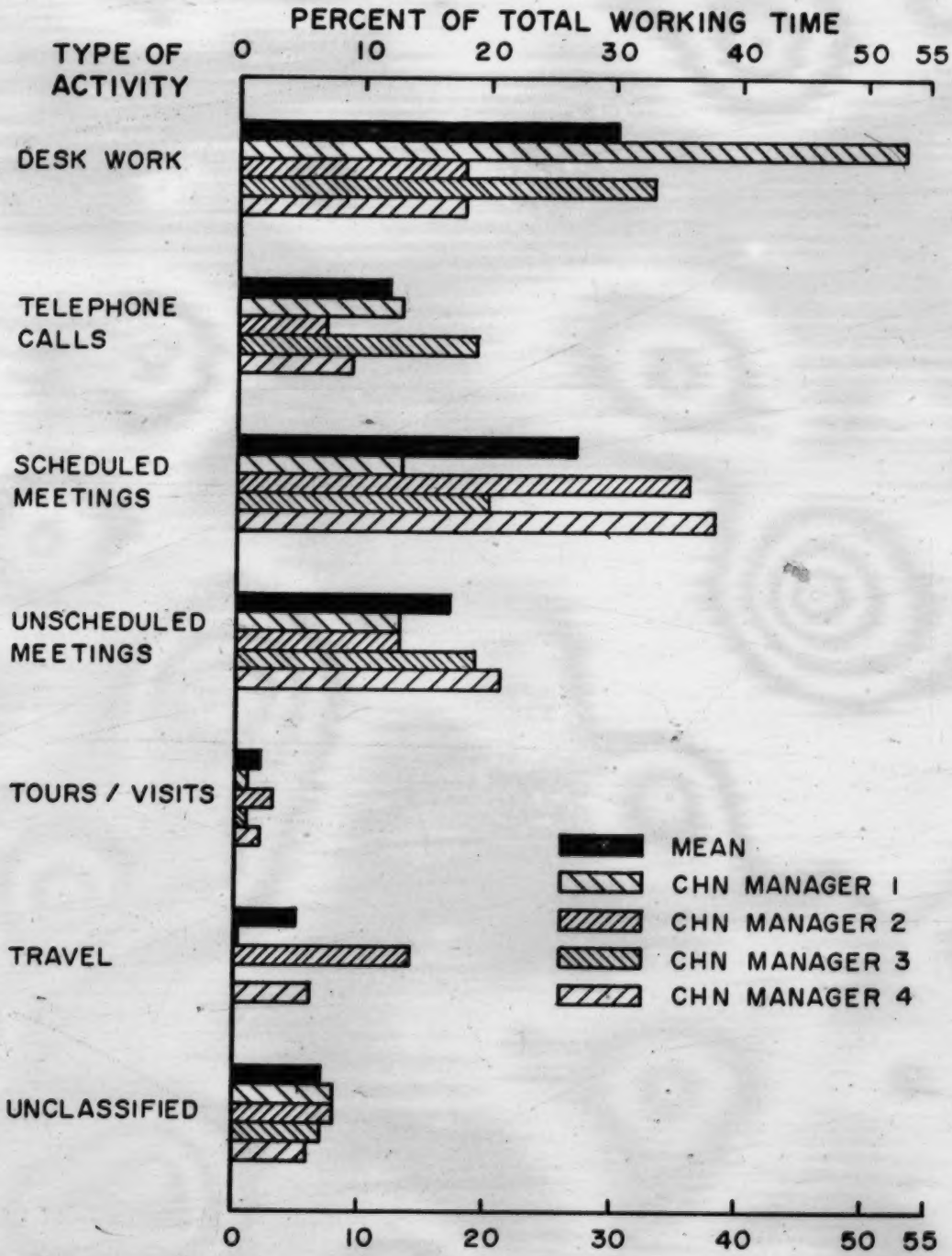
Summary of Community Health Nursing Managers' Types of Activity

Category	Mean	Community Health Nursing Manager 1	2	3	4
AVERAGE TIME WORKED PER DAY-minutes	456	425	433	498	468
-hours	7.6	7.1	7.2	8.3	7.8
PROPORTION OF TIME PER DAY IN:					
-desk work sessions	30%	53%	18%	33%	18%
-telephone calls	12%	13%	7%	19%	9%
-scheduled meetings	27%	13%	36%	20%	38%
-unscheduled meetings	17%	13%	13%	19%	21%
-tours and visits	2%	1%	3%	1%	2%
-travel	5%	0[a]	14%	-	6%
-unclassified activities[b]	7%	8%	8%	7%	6%

[a]When rounded to the nearest whole number, rounds to zero.
[b]Interactions with secretaries or personal activities.

FIGURE 3

COMMUNITY HEALTH NURSING (CHN) MANAGERS' TYPES OF ACTIVITY BY PROPORTION OF TIME



meetings which she regularly attends each month. Conversely, community health nursing manager 2 stated that I had observed typical work except for "quiet-time" activities, such as preparation of manuals and revision of policies and procedures.

The relatively large proportion of time spent on desk work (30% overall) may be partly due to the shortage of clerical support in all four Health Units. At the time of observation, none of the community health nursing managers had a personal secretary, although usually one clerical staff member did most of their typing. The community health nursing manager's mail was not sorted in any of the four Health Units (e.g., periodicals sorted from letters and specific reports; typing being returned for signature sorted from new mail). None of the community health nursing managers had clerical staff doing their filing during observation, although one of the four mentioned that this was a temporary situation and when a vacant clerical position was filled she would receive such assistance again. One community health nursing manager stated "some day I'd like to have a secretary, but it's probably a forlorn hope."

The next most time-consuming types of activity on average are unscheduled meetings and telephone calls, both of which showed somewhat more consistency across community health nursing managers than did desk work or scheduled meetings. All the community health nursing managers spent some time on tours, but this was a very small proportion of

time. The time spent in unclassified activities was about 7% of the total working time and varied little across the community health nursing managers.

The category of travel showed considerable variation among the community health nursing managers. The reason for the large variation is that community health nursing managers 2 and 4 each made at least one visit to a suboffice during the time of observation; community health nursing managers 1 and 3 did not and both commented that this was a typical activity that the researcher had not observed. The proportion of time spent on travel is probably biased toward a low figure in these results because travel to meetings outside the Health Unit was purposely excluded from the observation period. All four community health nursing managers have regularly scheduled meetings with external agencies in their Health Unit area and outside their Health Unit (i.e., regional or provincial meetings) from three to five times per month on average. All of these meetings involve travel time; the amount of time depends not only on the location of the meetings, but also on whether or not other activities are scheduled in conjunction with the meeting.

The average number of activities per day and the average duration of each type of activity are shown in Table 6 and Figures 4 and 5. These two types of data help to explain why desk work and scheduled meetings are the most time-consuming types of activity. The most frequent type of

Table 6

Summary of Community Health Nursing Managers' Number and Duration of Activities by Type of Activity

Category	Mean	Community Health Nursing Manager 1	2	3	4
AVERAGE NUMBER OF ACTIVITIES PER DAY:					
-all activities	39	48	31	42	36
-desk work sessions	14	20	8	15	12
-telephone calls	11	14	8	15	7
-scheduled meetings	4	2	6	2	5
-unscheduled meetings	9	10	7	10	10
-tours and visits	1	1	1	0[a]	1
-travel	1	0[a]	2	-	2
AVERAGE DURATION OF ACTIVITIES IN MINUTES:					
-all activities	12	9	14	12	13
-desk work sessions	10	11	10	11	7
-telephone calls	5	4	4	7	6
-scheduled meetings	33	23	27	50	38
-unscheduled meetings	8	6	8	10	10
-tours and visits	11	4	14	10	13
-travel	25	3	37	-	17

Note. All times are in minutes and have been rounded to the nearest minute.

[a]When rounded to the nearest whole number, rounds to zero.

FIGURE 4

COMMUNITY HEALTH NURSING (CHN) MANAGERS' AVERAGE NUMBER OF ACTIVITIES PER DAY BY TYPE OF ACTIVITY

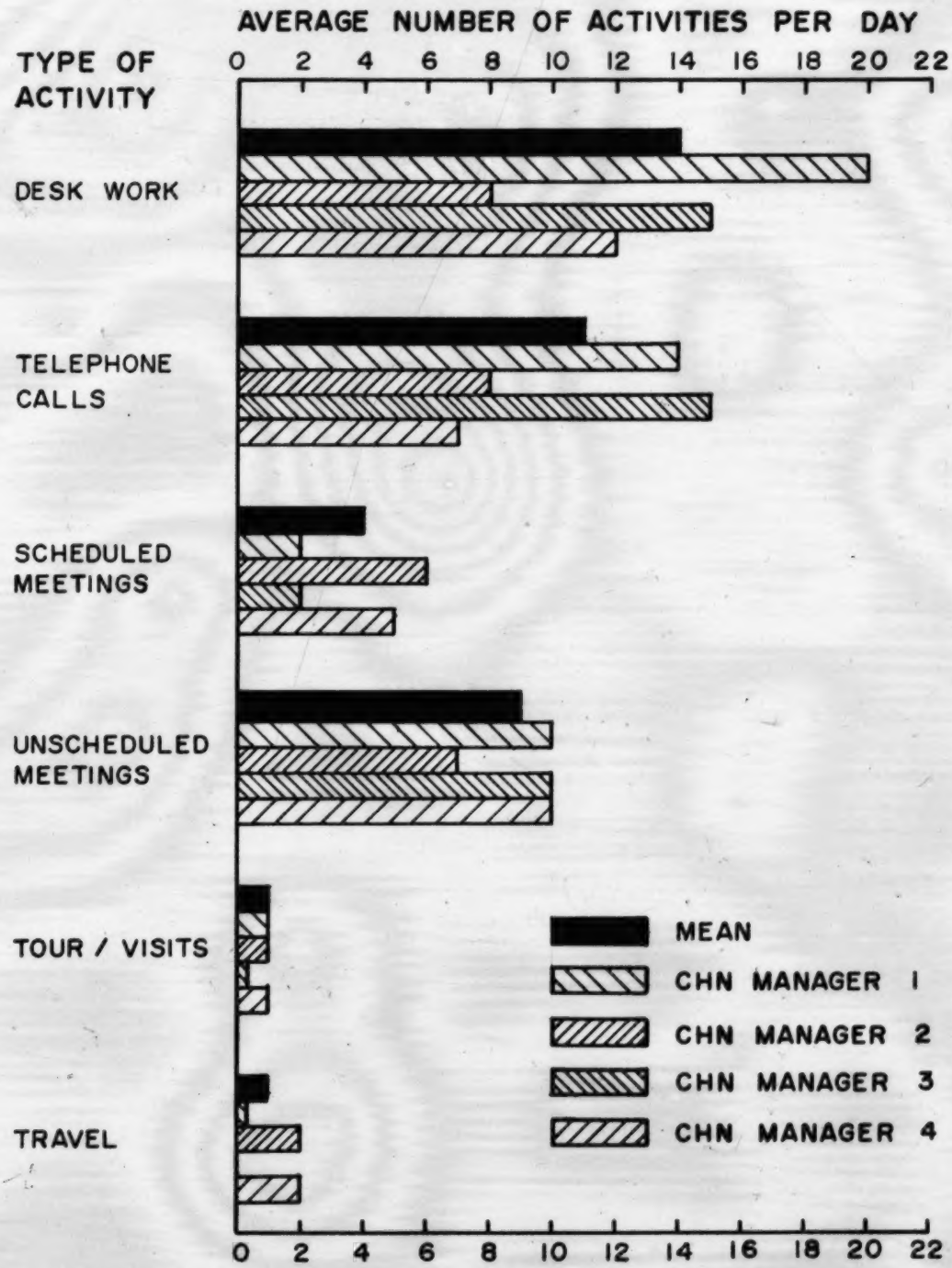
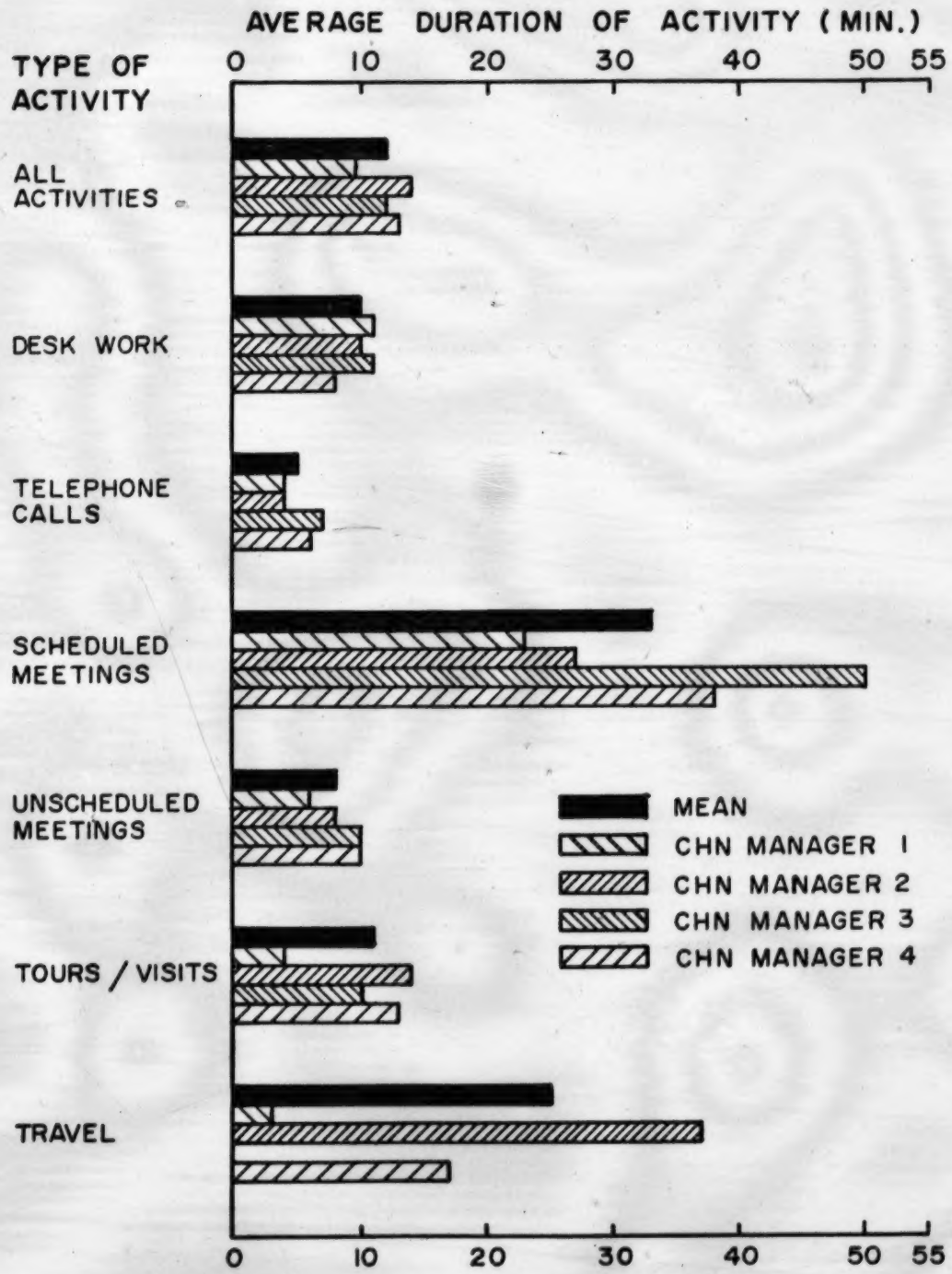


FIGURE 5

COMMUNITY HEALTH NURSING (CHN) MANAGERS' AVERAGE DURATION OF ACTIVITIES BY TYPE OF ACTIVITY



activity for all four community health nursing managers is desk work with an average of 14 out of the 39 activities occurring in a day. The activity of longest duration for three community health nursing managers and the longest duration on average was scheduled meetings with slightly over a half hour per meeting. Community health nursing manager 2 had travel of longer duration. These two types of activity may be of longer duration because they are relatively uninterruptable in comparison to other types of activity.

In terms of duration of activities it can be seen that the community health nursing managers had frequent changes of activity, as the average duration of all activities was 12 minutes. In other words, on average the community health nursing manager was involved in a different type of activity every 12 minutes throughout the working day. Another perspective regarding the short duration of the majority of activities is shown in Table 7. A little over half of the activities of all four community health nursing managers lasted 5 minutes or less; nearly 70% lasted 9 minutes or less. As shown in Table 7 there is remarkable consistency across community health nursing managers in relation to duration of activities.

Approximately 40% of the time spent in desk work sessions was spent handling mail (see Table 8). The community health nursing managers handled an average of 23 pieces of mail per day in an average of 54 minutes time. On

Table 7

Duration of Activities of Community Health Nursing Managers by Percentage of Total Activities

Duration of Activities	Mean	Community Health Nursing Manager 1	2	3	4
0 - 5 minutes	56%	58%	55%	52%	54%
6 - 10 minutes	15%	19%	16%	14%	16%
11 - 30 minutes	20%	17%	19%	26%	19%
31 - 60 minutes	5%	6%	6%	5%	5%
61+ minutes	3%	-	3%	2%	5%

Table 8

Summary Regarding Community Health Nursing Managers' Mail

Category	Mean	Community Health Nursing Manager 1	2	3	4
Average number of pieces of mail per day	23	32	13	31	17
Average time per day (in minutes) spent handling mail	54	78	30	70	36
Time handling mail as proportion of time spent on desk work	39%	35%	38%	42%	43%
PROPORTION OF MAIL TIME ON: -incoming mail	70%	82%	95%	46%	73%
-outgoing mail	30%	18%	5%	54%	27%
PROPORTION OF INCOMING MAIL TIME ON: -incoming reports	39%	48%	8%	49%	41%
-incoming letters	26%	20%	34%	28%	30%
PROPORTION OF OUTGOING MAIL TIME ON: -outgoing memos	71%	88%	80%	79%	12%

average handling incoming mail occupied 70% of this time while preparing outgoing mail took 30% of the time. Overall two-thirds of the time spent on incoming mail was spent on mail in the form of either a report or a letter, while overall at least two-thirds of the time spent on outgoing mail was spent on internal memos. Community health nursing managers 1 and 3 handled twice as many pieces of mail and spent twice as much time dealing with mail as community health nursing managers 2 and 4. Community health nursing manager 1 receives all community health nursing mail; the mail pertinent to her assistant and/or staff is forwarded to them by her. Both community health nursing managers 1 and 3 dealt with the Medical Officer of Health's mail during part of the observation period; they sorted and forwarded to the appropriate program director any mail which should not be delayed by a temporary absence of the Medical Officer of Health. Community health nursing managers 2 and 4 did not receive community health nurses' mail or Medical Officer of Health's mail during the observation period.

In summary, in this section it has been reported that in an average day of 7 1/2 hours total working time, the community health nursing manager spent:

2 1/4 hours on desk work (of which 1 hour was on mail handling),

2 hours in scheduled meetings,

1 1/4 hours in unscheduled meetings,

1 hour in telephone calls,

1/2 hour in tours/travel, and

1/2 hour in unclassified activity.

The day's working time was used in an average of 39 separate activities, with 7 out of 10 averaging 9 minutes or less in duration and only 3 out of 100 lasting longer than an hour.

4.2.2 Participants in Activity

In the following analysis, the community health nursing manager's activities were considered in terms of the participants involved. First, the activities were considered as to whether they were undertaken alone (solitary activities) or with other people (joint activities). Next, the joint activities were considered in terms of who the participants were; that is, were they persons internal or external to the Health Unit? These two categories of participants are then further subdivided. A summary of these analyses appears in Table 9. (Further detail is included in Appendix D.3.) The analysis of types of activity in section 4.2.1 can be linked with the first stage of this analysis if it is realized that solitary activities include desk work and travel, while joint activities include all meetings and telephone calls and most of the tours.

It can be seen that solitary activities on average required one-third of the community health nursing manager's time while joint activities utilized about 60% of the time. The major exception to this pattern occurred with community health nursing manager 1 whose solitary activities occupied

Table 9

Summary of Community Health Nursing Managers' Activities by Category of Participant

Category	Mean	Community Health Nursing Manager 1	2	3	4
PROPORTION OF TIME PER DAY[a]:					
-in solitary activities	35%	53%	33%	33%	23%
-in joint activities	58%	39%	59%	59%	71%
PROPORTION OF JOINT ACTIVITY TIME WITH:					
-internal participants	65%	73%	74%	47%	72%
-external participants	35%	27%	26%	53%	28%
AVERAGE DURATION OF:					
-solitary activities	11	11	15	11	8
-joint activities	11	6	12	11	14
-activities with internal participants	10	6	13	8	16
-activities with external participants	11	6	9	16	12

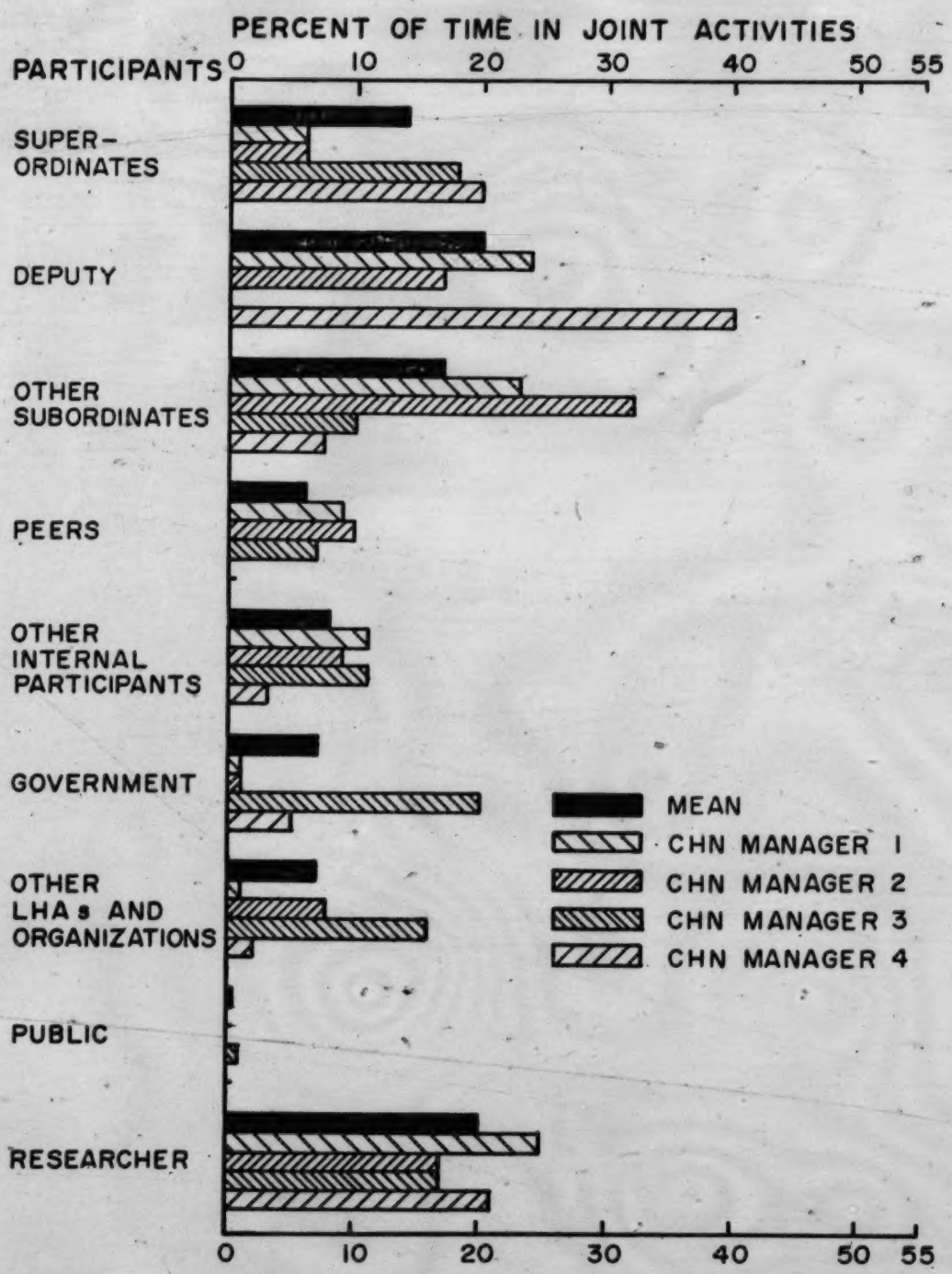
Note. All times are in minutes and have been rounded to the nearest minute.

[a]Unclassified activities as shown in Table 5 were not classified according to participant. Thus, the time accounted for here represents 93%, 92%, 92%, 92% and 94% of total working time respectively.

one-half of her time and joint activities took only slightly more than one-third of her time (39%). Some reasons for this exception are the following: community health nursing manager 1 was observed at a time when meetings away from the Health Unit had taken up 8 working days of the four weeks prior to observation; and a second Assistant Supervisor had been appointed within the past year, which she stated had changed her role so it now involved more desk work than previously.

Joint activities were considered in terms of participants who were internal to the Health Unit compared to those who were external to the Health Unit. On average two-thirds of the time community health nursing managers spent on joint activities was spent with other staff within the Health Unit and one-third with those outside the Health Unit. This average conceals one very interesting difference among the community health nursing managers. Three of the four community health nursing managers divided their time in almost exactly the same proportions: three times as much time was spent with internal participants as was spent with external participants. Community health nursing manager 3 spent nearly equal proportions of time with internal and external participants. Some reasons for this major difference become more apparent when Figure 6 is studied. Community health nursing manager 3 does not have an Assistant Supervisor or any staff member who seems to act in the role of deputy, which on average was the one category of

FIGURE 6
PARTICIPANTS IN
COMMUNITY HEALTH NURSING (CHN) MANAGERS'
JOINT ACTIVITIES BY PROPORTION OF TIME



participant which occupied the largest proportion of the community health nursing manager's time. Perhaps partly because she did not have a deputy, community health nursing manager 3 spent the most time in telephone discussions with community health nursing managers in other Health Units. Community health nursing manager 3 stated that being in a small community meant that she "can't be isolated," and she had more contacts with representatives of other health-related agencies in her community than did the other community health nursing managers. Community health nursing manager 3 also had one lengthy meeting with a government representative who was providing updated information regarding a particular program area, a typical, but infrequently-occurring activity. A visit by a government consultant to the Health Unit presents an opportunity for thorough discussion of a program; it seems that the community health nursing managers also utilize the opportunity to get many questions answered, resulting in lengthy scheduled meetings on such days.

The average duration of activities is also shown in Table 9. Although the mean value for solitary and joint activities was the same, 11 minutes, there were differences among the four community health nursing managers. Community health nursing managers 2 and 3 had fairly similar average durations for solitary and joint activities, but community health nursing manager 1 spent nearly twice as long on solitary activities as on joint activities, while the

opposite pattern occurred for community health nursing manager 4.

The considerable variation in proportions of time spent with different categories of participants is shown in Figure 6. (Actual times and proportions of time are shown in Appendices D.4 and D.5.) Much of this variation can be explained by the particular circumstances occurring at the times of observation.

In the case of superordinates, for community health nursing managers 1 and 2 the Medical Officer of Health was not at the same office as the community health nursing manager for 2 out of the 3 observation days. Both community health nursing managers 3 and 4 had the Medical Officer of Health at the office for 2 of the 3 days; community health nursing manager 3 also had a Board meeting on one of the observation days and community health nursing manager 4 had specifically scheduled extra time with the Medical Officer of Health because they had not both been in the Health Unit at the same time for 7 or 8 working days prior to the first day of observation.

As mentioned previously community health nursing manager 3 had no deputy (assistant), so no time was spent with that category of participant. Community health nursing manager 4 had a relatively new Assistant Supervisor and most of one day out of the three spent in observation had been scheduled for a planning meeting with the Assistant.

The proportions of time spent with staff community health nurses (other subordinates) showed considerable variation as well, although the overall mean value may be the best indicator of the long-term proportion of time spent with other subordinates. Community health nursing manager 1 had two regularly-scheduled and relatively lengthy planning meetings during the three days of observation, one with a group of staff community health nurses, and one with the Hereditary Diseases Program Nurse. Community health nursing manager 2 conducted three performance appraisals and also had a planning meeting in relation to one program area. These activities are typical, but are unlikely to occur on a weekly basis, so it is not surprising that community health nursing managers 3 and 4 did not undertake such activities during the period of observation. The three community health nursing managers who have Assistant Supervisors stated that they have more frequent contact with staff community health nurses and with the public when their Assistants are away from the Health Unit. Many of the day-to-day concerns of the community health nurses are dealt with by the Assistants, who seem to have a more supervisory (semidirect client service or operational control) role, whereas the community health nursing managers seem to have a more managerial (indirect client service or management control) role. The community health nursing manager who did not have an Assistant Supervisor stated that she has two roles, Supervisor and Manager, and she "tries to juggle both," but

that during the observation period she had been primarily the Manager.

The proportions of time spent with other program directors (peers) or members of departments other than nursing were fairly consistent across community health nursing managers. The one exception was community health nursing manager 4 who spent a much smaller proportion of time with these categories of participants than did the other three community health nursing managers; this may have been due to the large proportion of time she spent with her deputy during the period of observation.

There was considerable variation in the proportions of time spent with the external participants. As mentioned previously community health nursing manager 3 had one lengthy meeting with a government representative; the other community health nursing managers spent relatively little time with persons from the government. Community health nursing managers 2 and 3 spent a larger proportion of time with personnel from other organizations (including other LHAs) than did community health nursing managers 1 and 4. Community health nursing managers 1 and 2 spent no time with members of the public during the observation period; community health nursing managers 3 and 4 did, but the proportion of time was very small.

The proportion of joint activity time spent specifically with this researcher is shown in Figure 6. The time includes the time spent in explanation of research

procedures, in the researcher-initiated interview on the third day, and in explanations the community health nursing managers gave about their activities and the situations they were dealing with. On average 20% of the community health nursing managers' joint activity time was spent with the researcher.

If those who sent mail to the community health nursing managers and those who received mail from the community health nursing managers are considered as participants, it can be seen in Table 10 that overall twice as much time was spent on incoming mail from persons external to the Health Unit as on mail from those in the Health Unit; overall the reverse is true in terms of outgoing mail. Considering all mail either received from or sent to persons internal to the Health Unit, half or more time on internal mail is spent on mail to or from subordinates other than the deputy. Time spent on mail from or to external persons is divided more or less equally between government personnel and persons from other organizations or LHAs.

4.2.3 Purposes of Activity (Administrative Behaviors)

The activities of the community health nursing managers were analyzed in terms of the purposes for the activities; that is, an attempt was made to answer the question for each and every observed activity: "why did the community health nursing manager do this?" When the activities had been sorted and grouped according to purpose (as described in

Table 10

Persons who Send Mail to or Receive Mail from Community Health Nursing Managers by Proportion of Time

Category	Mean	Community Health Nursing Manager 1	2	3	4
INCOMING MAIL:					
-internal persons	35%	59%	15%	16%	20%
-external persons	65%	41%	85%	84%	80%
OUTGOING MAIL:					
-internal persons	72%	93%	80%	80%	12%
-external persons	28%	7%	20%	20%	88%
INTERNAL PERSONS:					
-other subordinates	54%	46%	76%	54%	100%
EXTERNAL PERSONS:					
-other organizations including other LHAs	52%	64%	59%	38%	50%
-government	44%	33%	28%	60%	50%

section 3.5.2) groups of purposes emerged which were described well by Mintzberg's ten managerial roles or categories for administrative behavior. Definitions of these managerial roles and example activities from the data of this study are listed in Table 11. Some activities performed by the community health nursing managers did not seem to be well described by Mintzberg's managerial roles; they are grouped in one major category called professional behaviors. The category of professional behaviors has been subdivided into the roles of professional leader, professional expert, and professional consultant. Definitions and example activities for these roles are also listed in Table 11.

The proportions of time spent on major categories of behavior are shown in Table 12 and Figure 7. The interpersonal, informational and decisional categories of behavior are those used by Mintzberg; the professional behaviors form the additional category developed in this study. The proportion of total working time spent on activities related to this study is shown separately as an unclassified purpose category since it is not known what use would be made of that time when the researcher was not present. It can be seen that overall 12% of the community health nursing managers' time was spent on activities related to this study; such activities included time spent discussing study procedures, conducting the interview on the third day, and the time the community health nursing managers spent volunteering explanations of a situation or

Table 11

Operational Definitions of Role Categories for Purposes of Activity

Role	Definition	Example Activities
INTERPERSONAL--PRIMARY FOCUS IS ON RELATIONSHIPS		
Figurehead[a]	the symbolic head of the CHN unit representing it in all matters of formality; obliged to perform legal, social or ceremonial duties	represents CHN unit at formal functions (building openings, receptions); signs documents for staff members' payments (overtime, vacation, sick leave, expense accounts); completes reference for former staff member; acts on behalf of MOH (briefing before and after his/her absence, receives mail and calls in his/her absence, issues directives re: LHA phones, cars, hours, etc.)
Leader[a]	responsible for guiding and motivating subordinates toward achieving the goals and objectives of the CHN unit and the LHA; responsible for hiring, evaluating, and remunerating staff; probes into activities of subordinates	review sessions with deputy to plan activities, to discuss issues and potential future activities, to orient the deputy to her role; tours to greet staff during suboffice visits; evaluates performance and reviews performance objectives; confers with community health nurses re: their responsibilities and workload, supervises activities, plans program adaptations; travel time to suboffices related to such duties
Liaison[a]	builds and maintains relationships with peers and others outside the CHN unit in order to gain favors and information (networking)	participates in outside organizations as Board or committee member; Society of CHN Supervisors meetings; interacts with those in other LHA units to

Note. CHN=community health nursing; MOH=Medical Officer of Health; LHA=Local Health Authority

[a]Definitions adapted from Mintzberg (1973a, pp. 92-93) and Hannah (1981, pp. 321-323); examples are derived from the data in this study.

Table 11 (cont.)

Role	Definition	Example Activities
Liaison (cont.)		co-ordinate activities with CHN; shares information with organizations outside the LHA (e.g., schools, hospitals, government)
INFORMATIONAL--FOCUS IS INFORMATION PROCESSING		
Monitor[a]	seeks and receives information to develop thorough understanding of CHN unit and its environment, to detect problems and opportunities, and to be informed for decision-making; results in CHN manager being the nerve center of internal and external information important to the unit	receives wide variety of information through mail and verbal contacts (in some LHAs all nursing mail goes to CHN manager first "for information" and then is forwarded to staff); records overtime, vacation and attendance at inservice education sessions; analyzes expenditures in relation to budget; analyzes statistical reports
Disseminator[a]	transmits information received from outsiders or subordinates to those in CHN unit; may be facts or information involving interpretation and integration of diverse value positions of unit's influencers in the environment	forwards mail to subordinates; passes on current information important to subordinates by telephone calls, in meetings or by newsletter sent to all CHN staff
Spokesman[a]	transmits information about the CHN unit into its environment, to keep the unit's set of key influencers and its public informed re: plans, policies and results; to lobby for CHN unit	communicates with MOH re: CHN activities; reports to Board; orients new Board members to unit programs; prepares Annual Report of unit activities and results; presents information re: changes in unit programs to total LHA staff; tries to obtain more clerical support

Note. CHN=community health nursing; MOH=Medical Officer of Health; LHA=Local Health Authority

[a]Definitions adapted from Mintzberg (1973a, pp. 92-93) and Hannah (1981, pp. 321-323); examples are derived from the data in this study.

Table 11 (cont.)

Role	Definitions	Example Activities
DECISIONAL--FOCUS IS ON MAKING DECISIONS ON SIGNIFICANT MATTERS		
Entrepreneur[a]	searches for opportunities to initiate and design "improvement projects" which bring about controlled change in the CHN unit; may supervise or delegate such projects	prepares information sheets for parents; develops methods to evaluate service; changes performance appraisal procedure; initiates committees to develop/update philosophy, standards for programs, record audit, manuals; holds strategy or review sessions to plan projects
Disturbance Handler[a]	reacts to important, unexpected change or situation which threatens CHN unit, such as conflict between subordinates or between the unit and another unit or another organization	deals with: parents' reaction to TV program re: adverse effects of immunization, school board's reaction to parents' complaints re: family life education, major problem with a subordinate, concern re: identity of community health assistants
Resource Allocator[a]	responsible for decisions re: protection or use of CHN unit's resources (money, time, facilities, equipment, supplies, manpower, reputation); in effect makes or approves all significant unit decisions	plans schedule; decides re: orders of supplies and equipment; considers requests to attend continuing education sessions or requests for changes in work schedules of subordinates; budgets
Negotiator[a]	responsible for major negotiations with other organizations on behalf of CHN unit	negotiates with: outside organization for use of space and volunteers, educational institutions for use of staff and clients in students' clinical experience, union to reach collective agreement

Note. CHN=community health nursing; MOH=Medical Officer of Health; LHA=Local Health Authority

[a]Definitions adapted from Mintzberg (1973a, pp. 92-93) and Hannah (1981, pp. 321-323); examples are derived from the data in this study.

Table 11 (cont.)

Role	Definitions	Example Activities
PROFESSIONAL--PRIMARY FOCUS IS ON THE EXPERTISE IN COMMUNITY HEALTH NURSING AS OPPOSED TO EXPERTISE IN MANAGEMENT		
Professional Leader[b]	promotes staff development; initiates, participates in, facilitates and uses research relevant to CHN; demonstrates commitment to own professional growth	plans inservice education and negotiates with resource persons; reviews periodicals and recommends articles to nurses; evaluates and compiles staff evaluations of education sessions; receives reports of study findings, discusses planned projects, provides information, ensures staff participation in special projects
Professional Expert[b]	advises community health nurses in difficult or unusual situations; advises other program persons in LHA in relation to CHN; collects program information to be able to provide this advice	discusses cases with staff members; recommends action with specific families; recommends involvement of other LHA program persons; reviews potential educational materials for use in CHN programs; meets with government program consultants
Professional Consultant[b]	acts as resource person re: CHN programs to those outside the LHA (local or provincial level)	reacts to proposals for new programs or adaptations of existing programs; recommends changes in regulations (e.g., communicable diseases); member of subcommittee of Standing Committee on CHN (e.g., records, prenatal, early postnatal discharge, standards)

Note. CHN=community health nursing; MOH=Medical Officer of Health; LHA=Local Health Authority

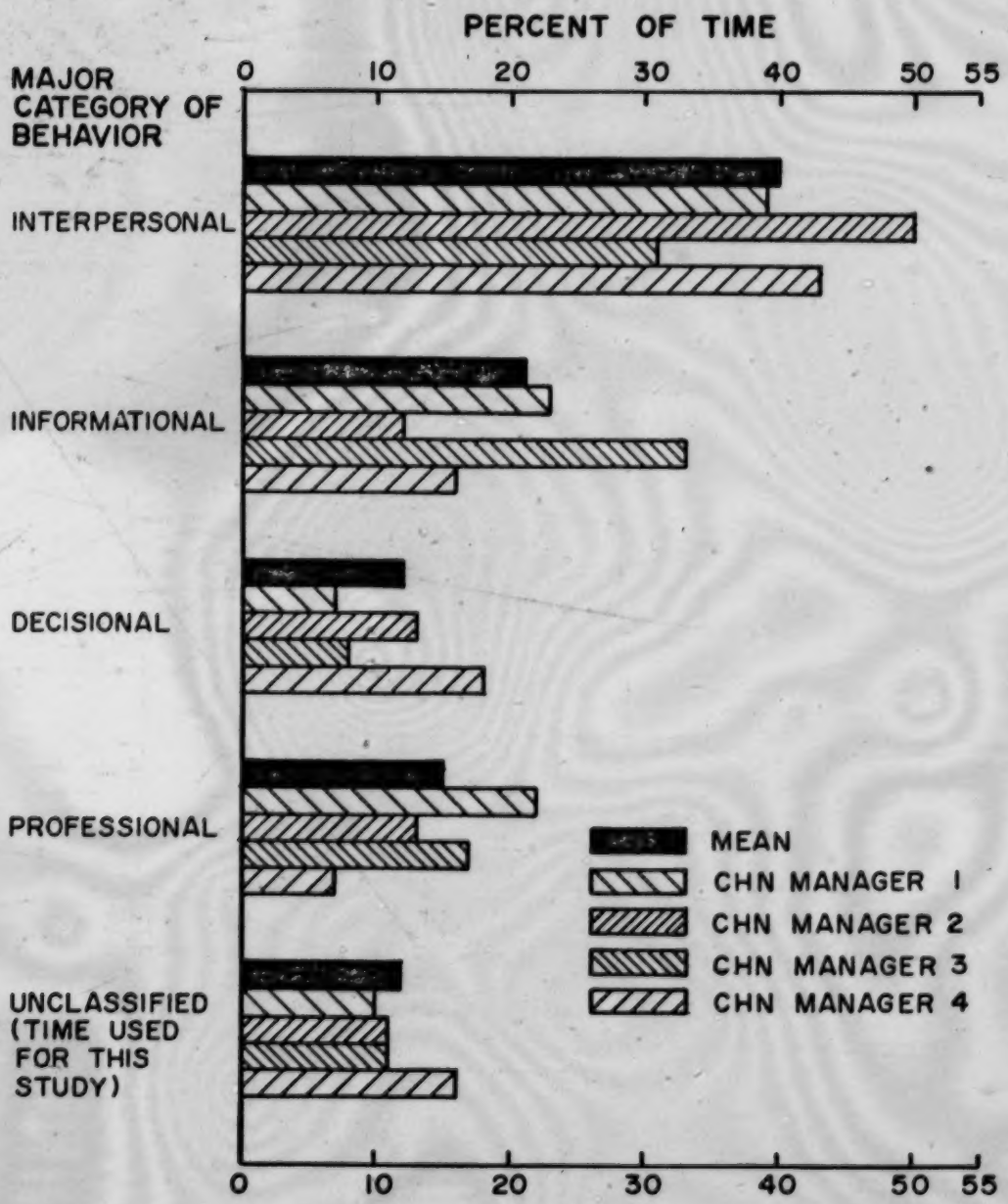
[b]Definitions developed from the data in this study.

Table 12

Summary of Community Health Nursing Managers' Major Categories of Behavior by Proportion of Time

Major Category of Behavior	Mean	Community Health Nursing Manager			
		1	2	3	4
PROPORTION OF TOTAL TIME IN:					
Interpersonal behaviors	40%	39%	50%	31%	43%
Informational behaviors	21%	23%	12%	33%	16%
Decisional behaviors	12%	7%	13%	8%	18%
Professional behaviors	15%	22%	13%	17%	7%
This study--behavior unclassified	12%	10%	11%	11%	16%

FIGURE 7
COMMUNITY HEALTH NURSING (CHN) MANAGERS' MAJOR CATEGORIES OF BEHAVIOR BY PROPORTION OF TIME



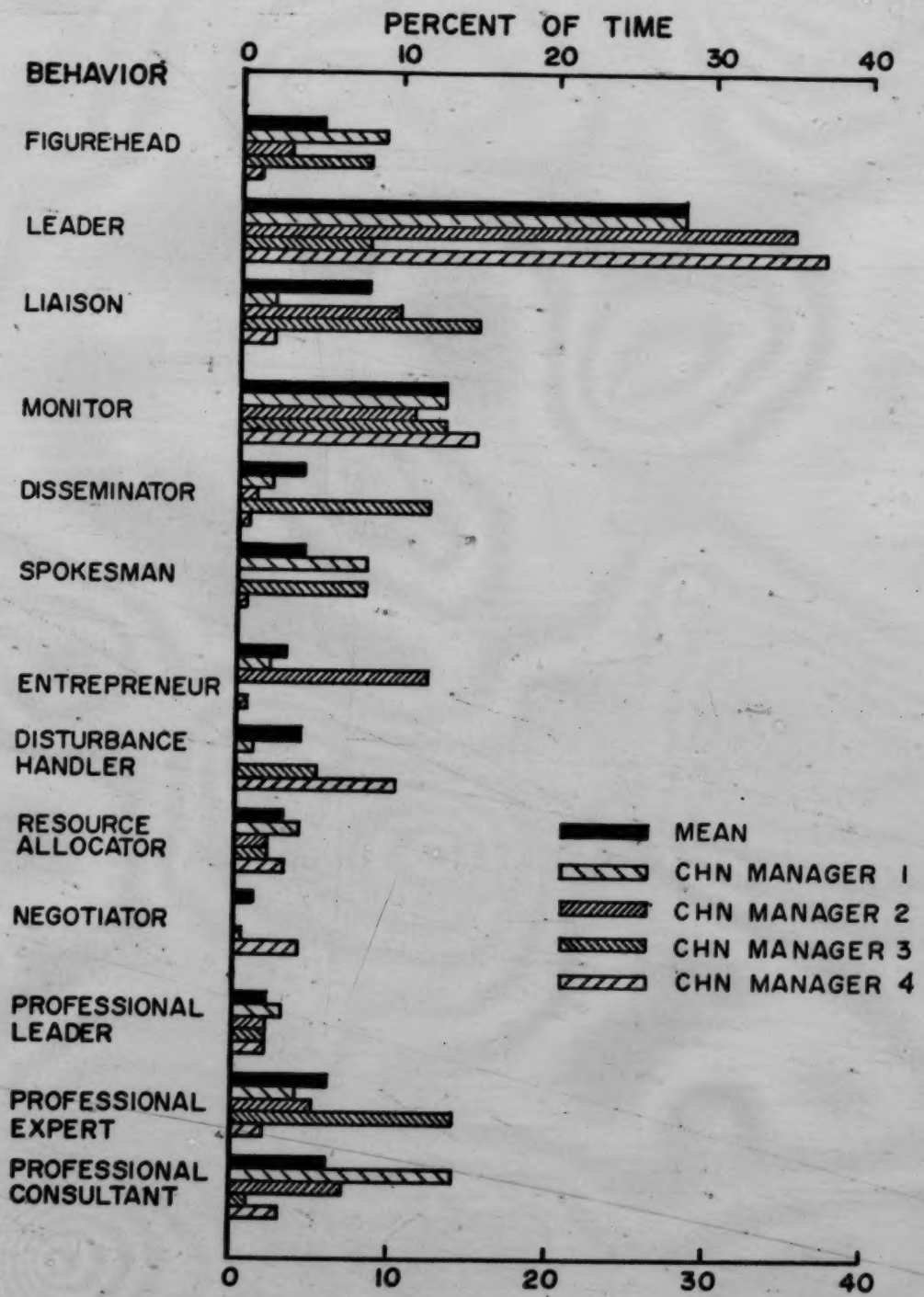
answering the researcher's questions.

Interpersonal behaviors occupied the largest proportion (one-third to one-half) of time for all community health nursing managers; the only slight exception to this is that community health nursing manager 3 utilized an equivalent proportion of time in informational behaviors. Overall informational behaviors were the second most time-consuming category, followed by professional behaviors with decisional behaviors taking the smallest proportion of time.

Each of the four major categories includes three or four related behaviors for a total of thirteen behaviors. The proportions of time spent by community health nursing managers in these thirteen behaviors are shown in Figure 8. The behavior or role which required the largest proportion of time overall, and for three of the four community health nursing managers was the leader role, taking up fully one-quarter to one-third of the total working time. Community health nursing manager 3 was the only one for whom the leader role was not predominant; she spent the single largest proportion of her time in another interpersonal role, the liaison role.

Of the three informational roles, the predominant role for all four community health nursing managers was the monitor role. The proportion of time used in this role was consistent across the community health nursing managers at about 13%. Time spent in each of the other two informational roles, disseminator and spokesman, was 4% overall. However,

FIGURE 8
COMMUNITY HEALTH NURSING (CHN) MANAGERS' CATEGORIES OF BEHAVIOR BY PROPORTION OF TIME



the time allocation among the managers varied widely. Community health nursing manager 3 spent 12% of her time as a disseminator; the other three community health nursing managers spent very little time in this role. Both community health nursing managers 1 and 3 spent 8% of their time as a spokesman.

Decisional roles overall required fairly equal proportions of time, but there was considerable variation among the community health nursing managers in the proportions of time required by the various decisional roles. Two community health nursing managers spent 10% or more of their time in one of the decisional roles; the other three decisional roles for these managers and all four decisional roles for the other two community health nursing managers occupied 5% or less of their total time. During the observation period community health nursing manager 2 utilized 12% of her time in the entrepreneur role, which was a far larger proportion of time than any of the other community health nursing managers spent in this role. This community health nursing manager had made a definite commitment to two improvement projects and indicated the importance by devoting a considerable amount of time to them. Similarly, community health nursing manager 4 spent 10% of her time in the disturbance handler role which was twice the proportion of time spent by any of the other community health nursing managers on this role. A situation which was causing concern among the community health nurses

required a considerable amount of her time during the observation period.

4.2.4 A Composite View of the Activities and Administrative Behaviors of the Community Health Nursing Manager

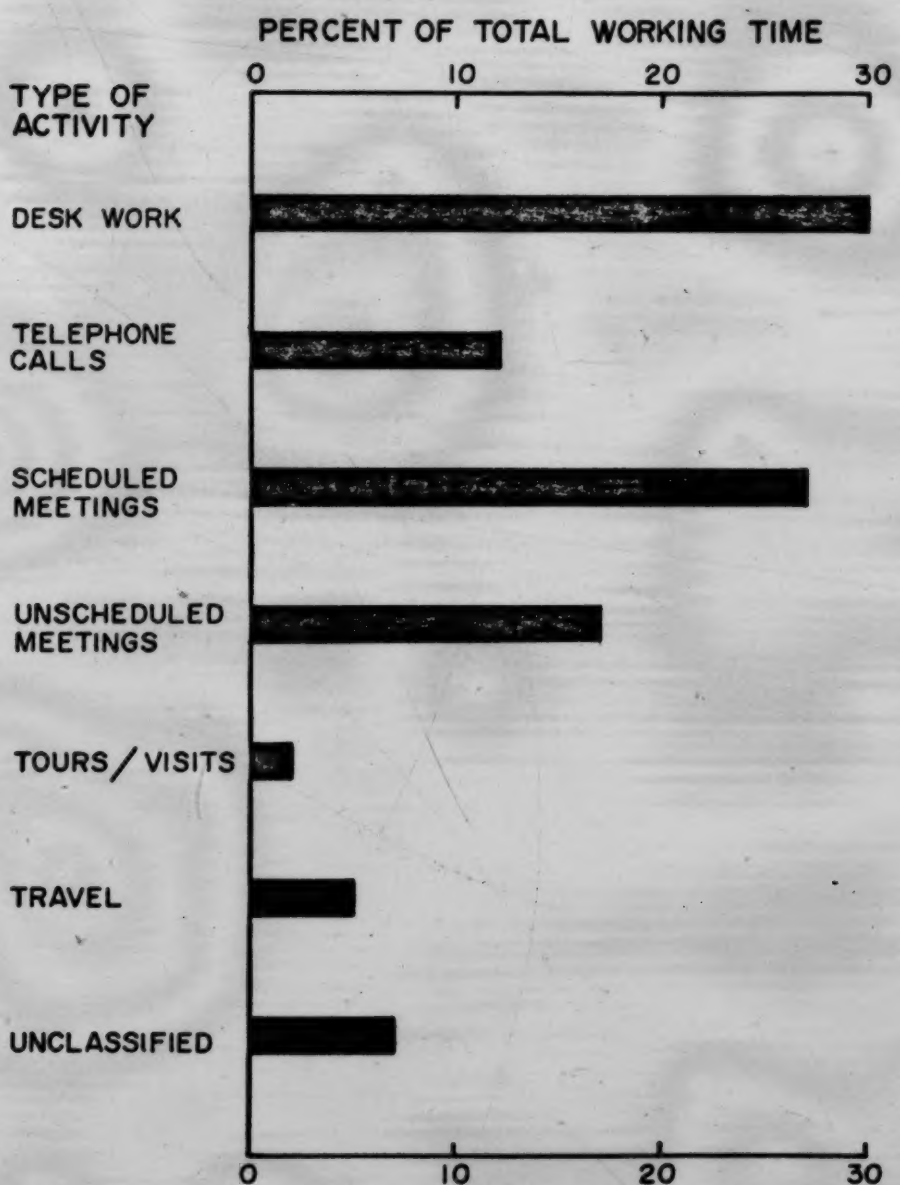
The mean values for all four community health nursing managers were reported in the previous sections for comparison with the individual values. In this section, the mean values for the four community health nursing managers will be reviewed in order to present a composite description of the activities and administrative behaviors of the community health nursing manager.

As reported in section 4.2.1 the community health nursing manager worked a 7.6-hour day on average. This time was divided by type of activity as shown in Figure 9. Desk work and scheduled meetings took the largest proportions of time and in actual situations one or the other activity predominated. That is, if there were several scheduled meetings major desk work activities were postponed, or if desk work had accumulated scheduled meetings were arranged a few days later to provide "catch-up" time.

Travel time probably requires a greater proportion of time than is actually shown because travel outside the Health Unit was deliberately not scheduled during observation.

On average the community health nursing managers engaged in 39 activities per day, of which almost 70% lasted

FIGURE 9
COMMUNITY HEALTH NURSING MANAGER'S
TYPES OF ACTIVITY
BY PROPORTION OF TIME (MEAN)



9 minutes or less and only 3% lasted more than one hour. On average throughout the day the community health nursing manager worked 12 minutes on an activity before being interrupted or changing to another activity. Scheduled meetings and travel were the longest duration activities, on average taking about one half-hour. Telephone calls, averaging 5 minutes per call, were the activity of shortest duration.

On the average, the 39 activities engaged in each day by the community health nursing managers were divided into: 14 desk work sessions in which 23 pieces of mail were processed, 11 telephone calls, 4 scheduled meetings, 9 unscheduled meetings, 1 tour and 1 travel session. In addition to the 11 telephone calls, an average of 4 other calls were made in which there was no answer or a busy line or a message had to be left for the person called. In handling mail, two-thirds of the time was spent on incoming mail and one-third on outgoing mail. The incoming mail which required the largest proportions of time were reports and letters from an organization outside the Health Unit or from the government; the major proportion of time spent on outgoing mail was spent on memos to subordinates.

On average the community health nursing managers spent one-third of their day in solitary activities and two-thirds of their day in joint activities. Two-thirds of this joint activity time was spent with persons within the Health Unit; one-third with persons outside the Health Unit. The

proportions of time spent with various categories of participants are shown in Figure 10. If time spent with the researcher is excluded, the three largest proportions of time in descending order were spent with the deputy, other subordinates and superordinates.

In terms of major category for behavior, community health nursing managers spent the largest proportion of time (40%) on interpersonal behaviors. The importance of the other three major categories of behavior, in descending order by time spent, was informational, professional and decisional. The roles or categories of behavior for the community health nursing manager are shown in Figure 11. The predominant role is that of leader. When time spent on this study is excluded, the roles ranked in descending order of importance after leader are monitor, liaison, professional expert, professional consultant, and figurehead, each of which required 5% or more of the community health nursing manager's time.

There were variations among the four observed community health nursing managers in the proportions of time allocated to participants in activity, types and purposes of activity. Some of these variations seemed to be explained by the circumstances in the Health Unit at the specific time of observation (e.g., "catch-up" desk work time or scheduled meeting time, government consultant being at the Health Unit); other variations appeared to be explained by the structure and organization of the particular Health Unit

FIGURE 10
PARTICIPANTS IN
COMMUNITY HEALTH NURSING MANAGER'S
JOINT ACTIVITIES BY PROPORTION OF TIME (MEAN)

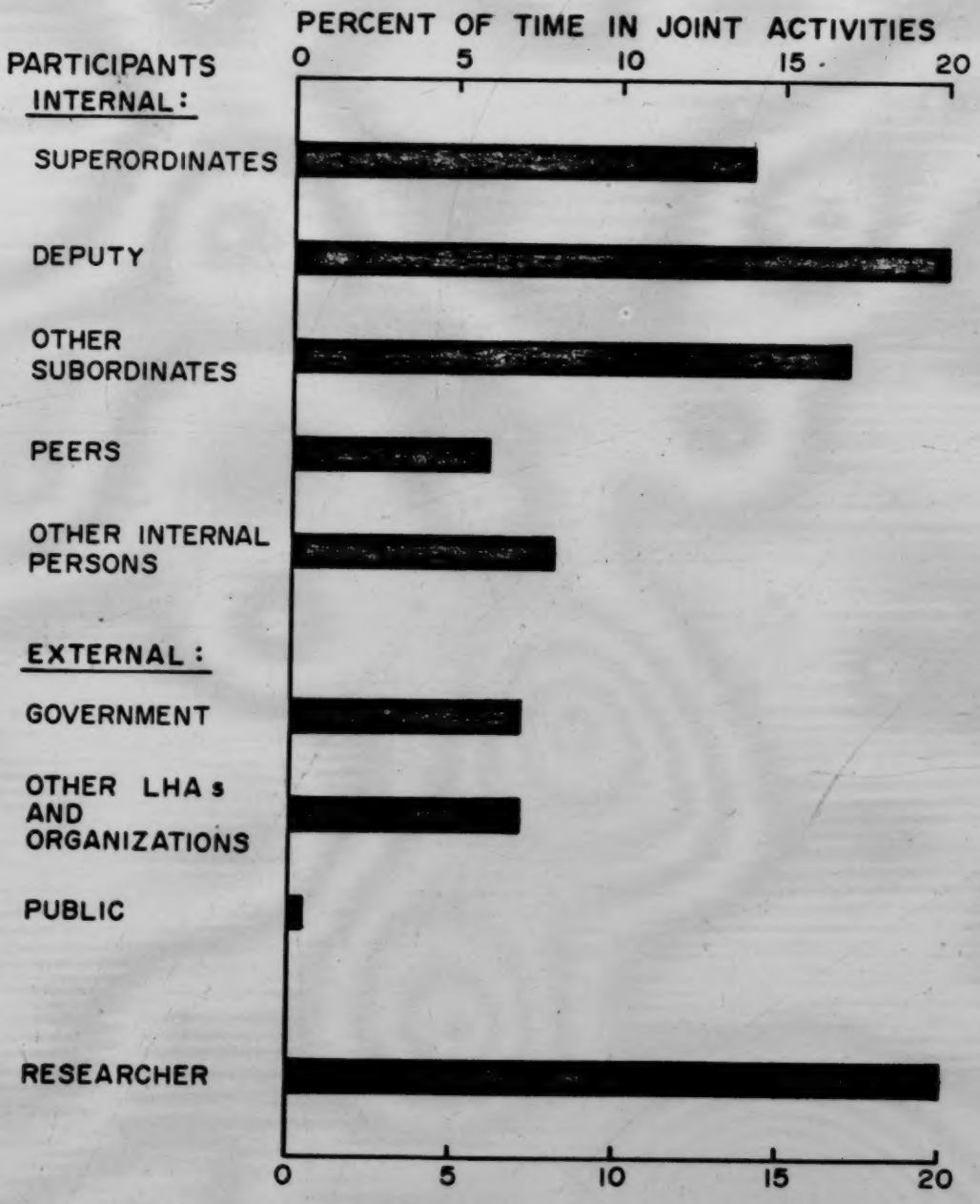
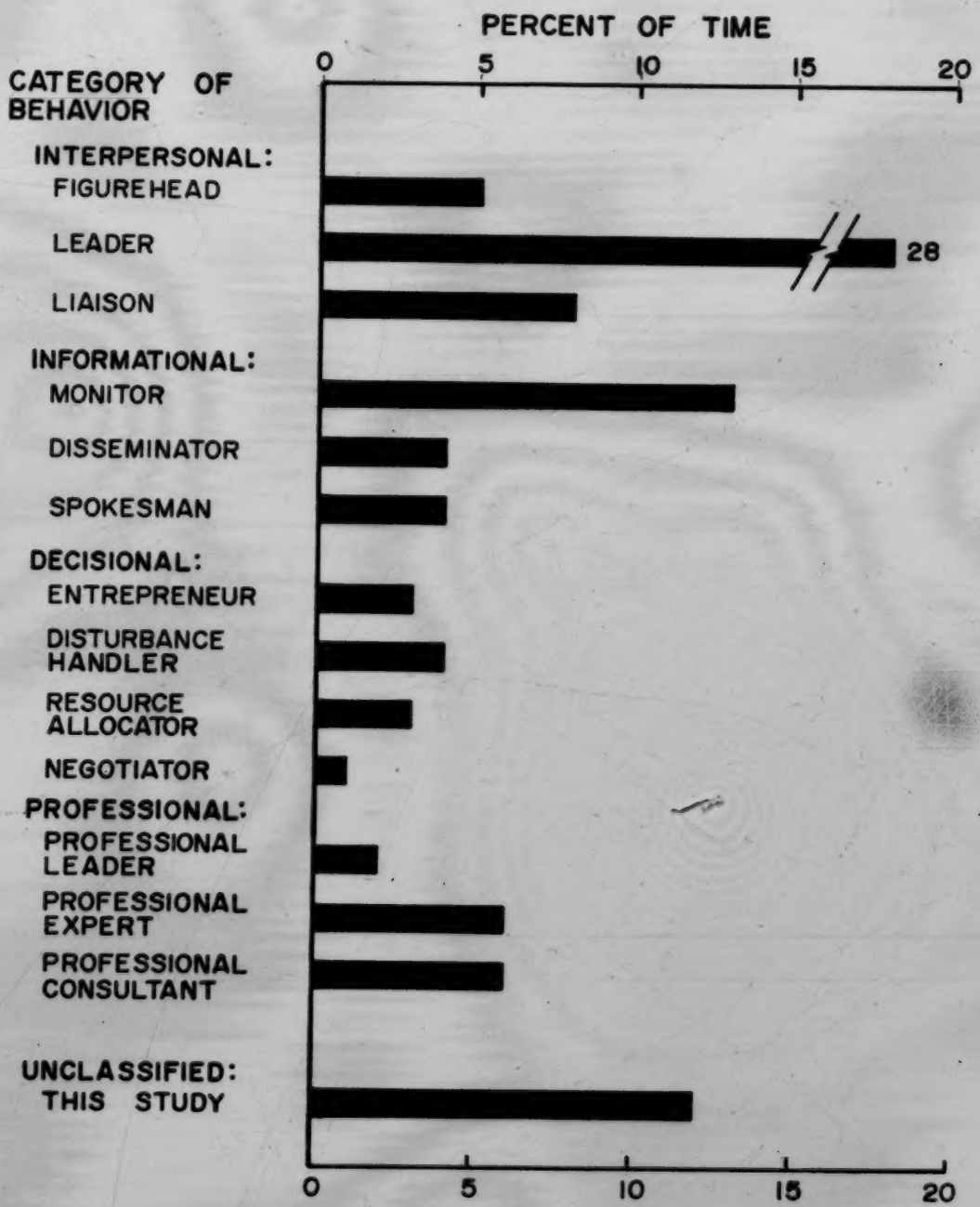


FIGURE 11
COMMUNITY HEALTH NURSING MANAGER'S
CATEGORIES OF BEHAVIOR
BY PROPORTION OF TIME (MEAN)



(e.g., whether or not there was an Assistant Supervisor, availability of support staff); it is also likely that some of the variation was due to the individuality of the community health nursing manager.

4.3 Comparison of Findings of Community Health Nursing Managers with other Structured Observation Studies of Managers

Highlights of the results presented in the previous section will be compared to the results of other structured observation studies of managerial work. The three subsections of section 4.2 will also be used in this section: (1) types of activity, (2) participants in activity, and (3) purposes of activity (administrative behaviors). Comparisons will be made with the results of studies of the chief executive (Mintzberg, 1973a), the small company manager (Choran, Note 1), the school superintendent (Duignan, 1979), and the dean of nursing (Hannah, 1981).

4.3.1 Types of Activity

Work characteristics of the five groups of managers studied by structured observation are highlighted in Table 13. Average hours worked per day ranged from a low of 6.4 (small company manager) to a high of 9.4 (dean of nursing). The community health nursing manager's 7.6 hours worked was the middle value of the five. The school superintendent,

Table 13

Selected Comparisons of the Work Characteristics of Different Managers (Mean for One Day)

Category of Comparison	Chief Executive (Mintzberg)	Small Company Manager (Choran)	School Super-intendent (Duignan)	Dean of Nursing (Hannah)	Community Health Nursing Manager
Hours worked	8.1	6.4	8.2	9.4	7.6
Number of activities	22	79	38	37	39
Average duration of each activity	22 min.	5 min.	13 min.	16 min.	12 min.
Proportion of activities lasting less than 9 minutes	49%	90%	62%	73%	69%
Proportion of activities lasting more than 60 minutes	10%	0.02%	3%	8%	3%

Note. Sources: Mintzberg (1973a, pp. 242-243); Choran (Note 1, pp. 64, 138); Duignan (1979, pp. 174, 176); Hannah (1981, pp. 257, 260).

dean of nursing and community health nursing manager had very similar average numbers of activities per day (38, 37, 39 respectively), and these three were in the middle of the range of values. The average duration of activities ranged from 5 to 22 minutes; the community health nursing manager's average duration of 12 minutes was very close to that of the school superintendent and in the mid-range. The community health nursing manager's results were also in the middle of the range of values for proportions of activities lasting less than 9 minutes or more than 60 minutes; the community health nursing manager's results were reasonably similar to those of the school superintendent and the dean of nursing.

Further detail about the types of activity of these five groups of managers is given in Table 14 and Figure 12. When the average numbers of different types of activity are considered it can be seen that in all five cases the community health nursing manager's results are more similar to those of the school superintendent and the dean of nursing than they are to those of the chief executive or small company manager. The average number of activities of the chief executive and the small company manager are the two extreme ends of the range and the number of activities of the school superintendent, dean of nursing and community health nursing manager fall between these two extremes (except for the number of scheduled meetings; the numbers are so similar that there is no range).

Table 14

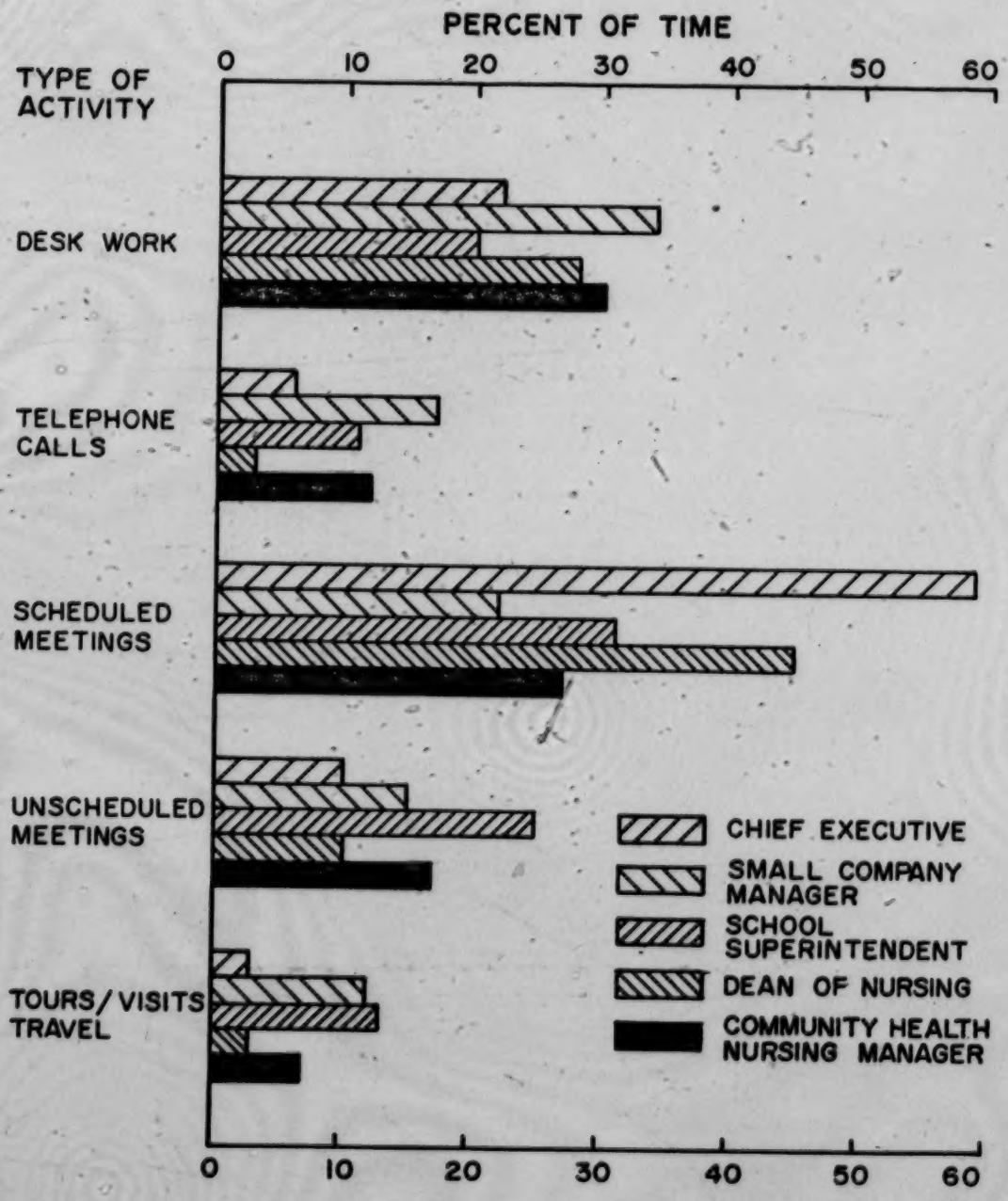
Selected Comparisons of the Types of Activity of Different Managers (Mean for One Day)

Category of Comparison	Chief Executive (Mintzberg)	Small Company Manager (Choran)	School Super-intendent (Duignan)	Dean of Nursing (Hannah)	Community Health Nursing Manager
DESK WORK SESSIONS					
Average number	7	21	10	13	14
Proportion of time	22%	34%	20%	28%	30%
Average duration	15 min.	6 min.	10 min.	12 min.	10 min.
TELEPHONE CALLS					
Average number	5	29	11	8	11
Proportion of time	6%	17%	11%	3%	12%
Average duration	6 min.	2 min.	5 min.	2 min.	5 min.
SCHEDULED MEETINGS					
Average number	4	3	3	4	4
Proportion of time	59%	22%	31%	45%	27%
Average duration	68 min.	27 min.	63 min.	64 min.	33 min.
UNSCHEDULED MEETINGS					
Average number	4	19	12	5	9
Proportion of time	10%	15%	25%	10%	17%
Average duration	12 min.	3 min.	10 min.	11 min.	8 min.
TOURS/VISITS/TRAVEL[a]					
Average number	1	5	3	2	2
Proportion of time	3%	12%	13%	3%	7%
Average duration	11 min.	9 min.	19 min.	10 min.	19 min.

Note. Sources: Mintzberg (1973a, pp. 242-243); Choran (Note 1, p. 138); Duignan (1979, p. 174); Hannah (1981, p. 257).

[a]Travel within the system is not reported by Mintzberg or Choran, so this comparison may be misleading.

FIGURE 12
TYPES OF ACTIVITY OF DIFFERENT MANAGERS
BY PROPORTION OF TIME



Consideration of the average duration of activities shows the community health nursing manager's durations to be very similar to those of the school superintendent except for scheduled meetings. The community health nursing manager and school superintendent's average duration of desk work sessions, telephone calls and unscheduled meetings are in the middle of the range; both have longer tour/travel sessions than the other managers. The school superintendent, dean of nursing and chief executive had the longest average scheduled meetings (slightly over one hour), while those of the community health nursing manager were only about a half hour, very close to the same duration as those of the small company manager.

The proportions of time spent on different types of activity can be seen graphically in Figure 12. For all managers scheduled meetings and desk work are the most time-consuming activities, with tours and travel consuming the smallest proportion of time. In all cases the community health nursing manager's proportions of time for a type of activity are in the middle of the range. The proportions of time spent by the community health nursing manager and the school superintendent are very similar for telephone calls and scheduled meetings; the community health nursing manager and the dean of nursing have similar proportions of time for desk work; the community health nursing manager and small company manager spend similar proportions of time in unscheduled meetings.

4.3.2 Participants in Activity

Selected comparisons of the joint activities of the five groups of managers are given in Table 15 (Mintzberg called these activities verbal contacts). The number of joint activities ranged from 15 to 57; the community health nursing manager (25) and school superintendent (26) had very similar numbers of activities in the middle of this range. The average duration of joint activities ranged from 4 to 28 minutes; again the community health nursing manager was most similar to the school superintendent and both had average durations in the middle of the range (11 and 13 minutes respectively).

The proportions of total working time spent on joint activities shows a different result. In this comparison the community health nursing manager is at the low end of the range of values, 58% (the small company manager's result was very similar); the school superintendent and dean of nursing have proportions of time in the middle of the range and the chief executive spent the largest proportion of time (78%) on joint activities.

In Table 16 selected comparisons of the participants in the five groups of managers' joint activities are shown. None of the other four studies reported the proportion of time spent with the researcher, so the community health nursing manager's proportions of time with categories of participants were recalculated after the time with the researcher was deducted; this was considered to give results

Table 15

Selected Comparisons of the Joint Activities of Different Managers (Mean for One Day)

Category of Comparison	Chief Executive (Mintzberg)	Small Company Manager (Choran)	School Super-intendent (Duignan)	Dean of Nursing (Hannah)	Community Health Nursing Manager
Number of joint activities	15	57	26	15	25
Average duration of each activity	26 min.	4 min.	13 min.	28 min.	11 min.
Proportion of time on joint activity	78%	59%	69%	73%	58%

Note. Sources: Mintzberg (1973a, pp. 250-251); Choran (Note 1, p. 149); Duignan (1979, p. 177); Hannah (1981, p. 262).

Table 16

Selected Comparisons of the Participants in Joint Activities of Different Managers by Proportion of Time

Category of Participant	Chief Executive (Mintzberg)	Small Company Manager (Choran)	School Super-intendent (Duignan)	Dean of Nursing (Hannah)	Community Health Nursing Manager[a]
INTERNAL PARTICIPANTS					
Superordinates	7%	-	23%	6%	17%
Subordinates	48%	56%	57%	33%	47%
Peers and other internal participants	-	4%	0.4%	29%	17%
EXTERNAL PARTICIPANTS					
Government	-	-	1%	0.3%	9%
Other organizations	33%	31%	1%	29%	9%
Clients and other external participants	11%	9%	17%	1%	0.5%

Note. Sources: Mintzberg (1973a, p. 250); Choran (Note 1, p. 149); Duignan (1979, p. 122); Hannah (1981; Hannah calculated proportions of time as a percentage of total working time; these proportions of joint activity time are calculated from data on p. 168).

[a]These percentages differ from those in section 4.2.2 because these percentages have been calculated as a proportion of joint activity time after time with the researcher was deducted.

which would be more directly comparable to those of the other four studies.

All of the five groups of managers spent more of their joint activity time with participants inside their organization than with those outside the organization. It should be noted that the chief executive and the school superintendent would only be able to relate to peers in other organizations outside their own; some of the small company manager had partners who were considered peers; the dean of nursing and the community health nursing manager both were the senior manager of their unit, but had peers within their organization, the university and the Health Unit respectively. The community health nursing manager and the school superintendent, who each spent four-fifths of their time with internal participants, had the highest proportion of time with internal participants.

All five groups of managers spent proportionally more time with their subordinates than they did with any other category of participants; in four out of five cases this took approximately one-half of their joint activity time. The community health nursing manager and school superintendent spent considerably more time with their superordinates than did the other managers. The community health nursing manager and the dean of nursing spent considerably more time with peers and other internal participants than did the other managers.

The community health nursing manager and the school superintendent spent the smallest proportion (one-fifth) of their joint activity time with external participants. The community health nursing manager spent by far the most time with government representatives. The community health nursing manager and the school superintendent spent a considerably smaller proportion of time with persons from other organizations than did the other managers. The community health nursing manager and the dean of nursing both spent very little time with clients and other external participants.

4.3.3 Purposes of Activity (Administrative Behaviors)

One major limitation is apparent when a comparison of purposes of activity for the five groups of managers is attempted. Mintzberg, Choran and Duignan categorized only the purposes of joint activities (called verbal contacts in their studies); this accounted for 59 to 78% of the working time of the managers they studied (see Table 15 in section 4.3.2). The categories of purposes used by these three are based on Mintzberg's earlier work (completed in 1968 and reported in 1973a, Appendix C). Mintzberg based the ten managerial roles he developed on his data and other studies of managers' work, but he did not use these roles in an operational way to measure the proportions of time the chief executives spent on each role. Hannah utilized Mintzberg's descriptions of the roles to classify all the dean of

nursing's activities according to purpose. The categorization of purposes completed in this study followed Hannah's method, and therefore, more detailed comparisons of purposes of activity or administrative behaviors will be made with the results of her study.

In Table 17 the proportions of time spent on the major categories of behavior for the five groups of managers are shown. The proportions of time reported by Mintzberg, Choran and Duignan are similar, and the proportions of time reported by Hannah are similar to those for the community health nursing managers. The differences between these two groups of results may reflect only the methodological differences between them.

Duignan did report another result which is not shown in Table 17. He concluded that some of the school superintendent's behaviors were not primarily managerial, but were more closely related to the superintendent's educational leadership role in the school. He found that 27% of the superintendent's time in joint activities had a primary educational purpose rather than an executive purpose. The dean of nursing's time in scholarly behaviors (20%) and the community health nursing manager's time in professional behaviors (15%) would seem to be categories similar to the school superintendent's educational behaviors.

More detail regarding the proportions of time spent on administrative behaviors by the dean of nursing and the

Table 17

Selected Comparisons of the Major Categories of Behavior of Different Managers by Proportion of Time

Major Category of Behavior	Chief Executive (Mintzberg)	Small Company Manager (Choran)	School Super-intendent (Duignan)	Dean of Nursing (Hannah)	Community Health Nursing Manager
Interpersonal	-	-	-	31%	40%
Informational	40%	36%	40%	29%	21%
Decisional	21%	27%	35%	12%	12%
Secondary	21%	21%	11%	-	-
Requests	18%	9%	15%	-	-
Scholarly	-	-	-	20%	-
Professional	-	-	-	-	15%

Note. Sources: Mintzberg (1973a, p. 251); Choran (Note 1, p. 150); Duignan (1979, p. 179); Hannah (1981, p. 265).
Mintzberg, Choran and Duignan reported time for the purposes of joint activities only. Hannah reported time for the purposes of all activities. In this study, time was reported for the purposes of all activity.

community health nursing manager is given in Table 18 and Figure 13. Both of these managers spent a larger proportion of time on interpersonal behaviors than on the other three categories (although the dean spent very close to the same proportion of time on informational behaviors). The largest single category for the community health nursing manager was the leader role; for the dean of nursing it was the monitor role. For both of these managers the predominant informational role was the monitor role. There is remarkable similarity in the proportions of time spent by the two managers in all of the roles except for the leader role. The times spent in scholarly behaviors and professional behaviors are considered as whole categories since the individual roles within these categories are not comparable; however, it would seem to be reasonable to consider scholarly behaviors to be the dean's professional behaviors.

4.3.4 Summary of Comparative Analysis

In the comparisons made with other structured observation studies the community health nursing manager's results were more similar to those of the school superintendent and the dean of nursing than they were to those of the chief executive and the small company manager. Frequently the results of the chief executive and those of the small company manager formed the extremes of the range of results in a particular category of comparison; the results of the community health nursing manager, the school

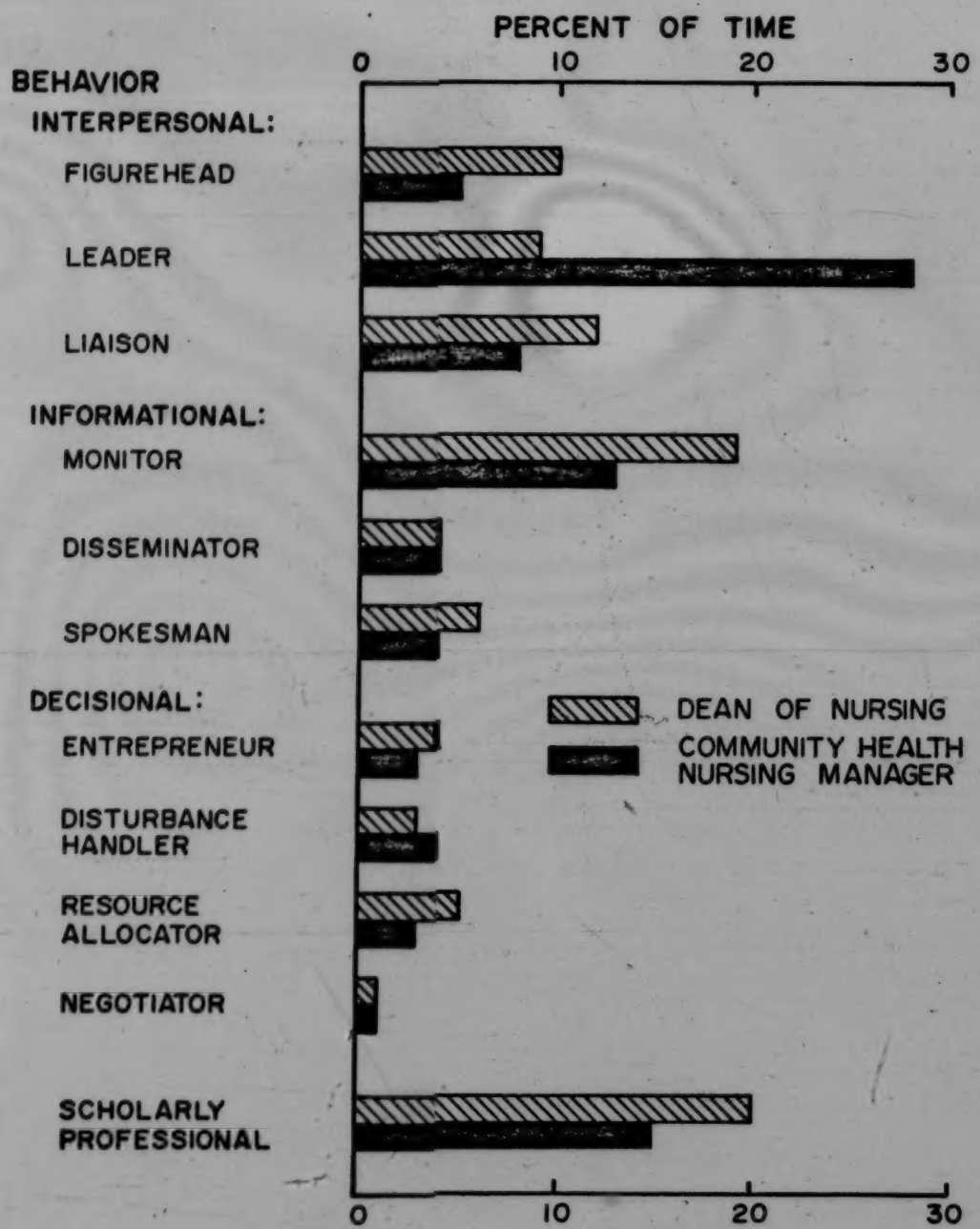
Table 18

Comparison of the Categories of Behavior of the Dean of Nursing and the Community Health Nursing Manager by Proportion of Time

Category of Behavior	Dean of Nursing (Hannah, 1981, pp. 247, 250)	Community Health Nursing Manager
INTERPERSONAL		
Figurehead	10%	5%
Leader	9%	28%
Liaison	12%	8%
INFORMATIONAL		
Monitor	19%	13%
Disseminator	4%	4%
Spokesman	6%	4%
DECISIONAL		
Entrepreneur	4%	3%
Disturbance Handler	3%	4%
Resource Allocator	5%	3%
Negotiator	1%	1%
SCHOLARLY		
Teacher	14%	-
Researcher	5%	-
Author	1%	-
PROFESSIONAL		
Professional Leader	-	2%
Professional Expert	-	6%
Professional Consultant	-	6%

Note. Hannah stated that the proportions of the deans' time not included in these percentages (7%) was unclassified behavior (p. 244). In this study, time which the Community Health Nursing Managers spent in activities related to this study is not included in the behavior categories (12% of time).

FIGURE 13
CATEGORIES OF BEHAVIOR
OF THE DEAN OF NURSING AND
THE COMMUNITY HEALTH NURSING MANAGER
BY PROPORTION OF TIME



superintendent, and the dean of nursing typically fell between these two extremes. The community health nursing manager's results showed close similarity to those of the school superintendent more often than to those of the dean of nursing.

Summary statements regarding similarities in the community health nursing manager's work will be proposed as an aid to further discussion regarding their work; Mintzberg, Duignan and Hannah called such statements propositions. Comparisons will be made between these propositions and those reported by Mintzberg, Choran, Duignan and Hannah.

1. Community health nursing manager's work has few breaks in the pace of activity through the work day.

   This work characteristic has been reported by Mintzberg, Choran, Duignan and Hannah in relation to the managers studied by them.

2. Community health nursing manager's work days are filled with a great number of short-duration activities. These activities involve a variety of issues with frequent interruptions requiring changes of focus to other issues.

   This is also a common characteristic reported by Mintzberg, Choran, Duignan and Hannah.

3. Community health nursing managers spend a larger proportion of time in joint activities than in solitary activities.

Mintzberg, Choran, Duignan and Hannah all reported that the managers studied by them spent most of their time in joint activities or verbal contacts.

4. Community health nursing managers are the link between the community health nursing unit and numerous other contacts. Although about one-half of the joint activity time was spent with subordinates, the other half was spent with a variety of persons both inside and outside the Health Unit.

   This was a common finding reported by Mintzberg, Choran, Duignan and Hannah.

5. Community health nursing managers experience conflict between their responsibility for development of community health nursing programs and community health nursing staff, and their responsibility for assistance to the Medical Officer of Health and other program directors in relation to total Health Unit administration. The expectations of the Medical Officer of Health and his way of working seemed to greatly influence the community health nursing managers' jobs. Supervision of community health nurses' practice seemed to be one major activity which was not performed when time commitments became too heavy. The community health nursing managers reported that they limited the amount of time they devoted to organizational work outside community health nursing. In discussing the responsibility for considerable general Health Unit

administration, one community health nursing manager stated that the disadvantage to this responsibility was "the time taken away from development of community health nursing programs" and that she had to work at ensuring that community health nursing was not deprived of the time it required. An example of assisting other program areas was evident in the area of performance appraisal; community health nursing has had a performance appraisal process in place for some time and when this was being extended to other program areas the community health nursing manager assisted with the implementation.

Duignan reported a similar characteristic about school superintendents, who saw themselves as the "man-in-the-middle" caught between their administrative responsibilities and their responsibility for educational leadership. Hannah reported that the deans of nursing were torn between the needs of the nursing faculty and the needs of the university as a whole. Mintzberg did not report this type of conflict for chief executives.

6. Community health nursing manager's work has seasonal patterns, but not daily or weekly patterns. The days show much variation, and one community health nursing manager commented that "that's the way the job goes." When the Assistant Supervisor is away from the Health Unit the community health nursing manager has more

contact with community health nurses and the public. Reported seasonal variations were related to inservice education opportunities for the staff, preparation of the budget or annual report, program planning (done once or twice per year), heavier meeting commitments in the fall and winter months, and summer months being busy with revisions of forms, manuals and procedures.

Duignan found that the school superintendent had daily, weekly and seasonal patterns to his work; Hannah reported seasonal variation in the dean's work. Mintzberg reported that there were no real patterns to the work of chief executives.

7. Community health nursing managers spent a significant amount of time on professional behaviors. This major category of behavior involved an average of 15% of the community health nursing manager's time, and was a definite pattern with all four managers. Another indication of this commitment is that the majority of time spent in the entrepreneur role during observation was related to improvements in community health nursing programs.

   Hannah found that the deans consciously committed themselves to scholarly behaviors, and suggested that the dean's professional credibility was an important factor in the amount of influence she had with faculty members.

8. For community health nursing managers the leader role

predominates. This category of behavior was allocated at least one-quarter of the time for three of the four managers. It would appear that development and motivation of staff members is a major concern of the community health nursing managers.

The leader role was not as predominant in Hannah's study.

9. Community health nursing managers are very independent and, to some extent, isolated in their role. The position of community health nursing manager has developed in each Health Unit independently. These managers had not received an orientation to their jobs, and have developed them as they worked in the jobs; those with Assistants have sorted out the distinction between their role and that of their Assistant independently as well. One community health nursing manager stated that this was a disadvantage of local autonomy. None of these community health nursing managers had ever had their performance evaluated by their Medical Officer of Health or Board. All commented that there is no real help for the community health nursing manager. As one community health nursing manager stated "one day you are a good community health nurse, and the next a Supervisor."
10. A shortage of support staff for the community health nursing manager and the community health nursing unit was a characteristic of all the observed Health Units.

4.4 Summary

In this chapter results of the study were presented and discussed. The first section included a description of the structure of the Health Units and the community health nursing units in which the observed community health nursing managers worked. Results of the observation of the activities of the four Alberta community health nursing managers were discussed in relation to types of activity, participants in activity and purposes of activity (administrative behavior). A composite description of the activities and administrative behaviors of the community health nursing manager which resulted from the analysis of the observational data was presented. This composite description was then compared to composite descriptions of the chief executive, the small company manager, the school superintendent and the dean of nursing which resulted from other structured observation studies with methodology similar to that used in this study.

5. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

The central question underlying this study was: What do community health nursing managers do in performing their role as community health nursing managers? The activities of community health nursing managers were observed and described, and their administrative behaviors were classified. In this chapter a summary of this descriptive study is presented, conclusions are drawn, and recommendations for community health nursing management and for further research are listed.

5.1 Summary

Current literature contains little information describing what community health nursing managers do in performing their role. To the knowledge of this researcher, the activities and administrative behaviors of community health nursing managers have not previously been studied by observation in their work setting. Such information would be useful to prospective and current community health nursing managers, to boards and directors who hire community health nursing managers, and to educators of community health nursing managers. The theoretical significance of this study lies in a comparison of the activities and administrative behaviors of community health nursing managers with those of other managers studied on the basis of similar methodology.

5.1.1 Summary of the Methodology

A structured observation field study was conducted in order to obtain a description of the activities and administrative behaviors of community health nursing managers. The study population was limited to the senior nursing managers in the Local Health Authorities (LHAs), the official community health agencies in Alberta. The study population was further limited to those community health nursing managers who had educational preparation in nursing at the baccalaureate degree level, who had been in their current position full-time and uninterrupted for at least one year, who were responsible for community health nursing programs but not primary care treatment programs, who were in small and medium-sized LHAs, and who had an LHA Director who had been in the position for at least one year. These limitations were designed to control extraneous systematic variance; it is recognized that they also limit the generalizability of the study findings.

Four community health nursing managers in Alberta LHAs were randomly selected from the study population, and were each observed for three working days while data were recorded regarding their activities. Data regarding the organizations within which they worked were collected and a description of the organizations was provided. The data resulting from the twelve days of observation were analyzed according to two approaches: (1) a molecular approach, in which the types of activity and participants in activity

were considered; and (2) a molar approach, in which the purposes of activity were categorized to determine administrative behaviors. A composite description of the activities and administrative behaviors of the community health nursing manager was developed. Comparisons of this description were made with those resulting from other structured observation studies of managers.

5.1.2 Summary of the Literature Review

Literature regarding nursing management and community health nursing management, the methodology of observational field studies, and the development and current structure of Alberta community health services was reviewed as a basis for this study.

5.1.2.1 Literature Related to Nursing Management

Currently in nursing management literature the use of theory borrowed from general management is predominant. Nursing management models can be considered as having a primary focus on one of five subjects: structure, process, content, the manager, or synthesis.

Two general management models appear to be the bases for most nursing management literature. One is the planning-organizing-directing-controlling cycle, a process model which is based on Fayol's management cycle. The other is focused on content, which has its basis in the POSDCORB functions of management developed by Gulick (planning,

organizing, staffing, directing, co-ordinating, reporting, budgeting). Very little nursing management literature focuses primarily on the structure of management. Considerable literature related to the nursing manager focuses on leadership rather than on management. Recently, nursing management authors have developed models which focus on synthesis rather than on structure, process, content or the manager.

The role of the nursing manager received increased attention during the 1970s and early 1980s. Many new nursing management texts and several new nursing management journals were first published, and conferences for nursing managers were first held during that time. Positions related to nursing management have been established in professional associations in Canada since 1976, and resolutions were passed in 1980 which called for action by the Canadian Nurses' Association in relation to nursing management.

Studies of the nursing manager's role indicate that the role was not clearly defined and role expectations are unclear. Most of the directors of nursing and nursing educators who have recently discussed the nursing manager's role state that it is a multiple role, and also noted that role expectations are not consistently defined. Several references to Mintzberg's model of managerial roles are included in recent nursing management literature; only two reports of studies were found which tested Mintzberg's model with nursing managers.

Most of the nursing management literature is focused on nursing management in hospitals. Very little literature has a primary focus on community health nursing management, and much of it was published prior to 1960. Two recent community health nursing texts include a chapter on management. Clemen et al. (1981) emphasize that all community health nurses must utilize management concepts. Brancich and Porter (1979) discuss the division of labor among three levels of community health nursing personnel. They state that the major responsibility of staff nurses is direct client service, whereas for supervisors the emphasis is upon semidirect client service, and for directors, indirect client service.

The nature of community health nursing is such that not all literature written for hospital nursing managers is relevant to or helpful for the community health nursing manager. Community health nursing services have a mandate to focus on primary prevention rather than secondary or tertiary prevention, to focus on groups of clients rather than individual clients, and to seek clients who need service rather than serving only those who have sought service. Over the past forty years, the focus of service has changed from a narrower emphasis on control of communicable diseases and provision of maternal-child health services, to a much broader focus dealing with a wide range of health promotion and illness prevention programs. Effectiveness and efficiency of these broad community health nursing services

are very difficult to measure.

Several authors have noted as recently as 1981 that there is a paucity of research in nursing administration. A study of the activities and administrative behaviors of community health nursing managers appeared to be timely and useful.

5.1.2.2 Literature Related to Methodology

Since no reports were found of observational studies of the community health nursing manager's work, and since a model of managerial roles based on observation (Mintzberg, 1973a) has been used to advantage in recent nursing management literature, a decision was made to use the methodology developed by Mintzberg in an observational field study of community health nursing managers. Mintzberg observed five chief executives of medium to large-sized United States organizations. He developed a set of ten managerial roles based on the purposes of the manager's activities which are grouped in three major categories: interpersonal, informational and decisional roles. Interpersonal roles include figurehead, leader, and liaison; informational roles include monitor, disseminator, and spokesman; decisional roles include entrepreneur, disturbance handler, resource allocator, and negotiator. Characteristics of managerial work as described by Mintzberg include: a great quantity of work was performed at an unrelenting pace; activities were characterized by brevity,

variety and fragmentation; the managers preferred live action and verbal media; the managers linked their organizations to a network of contacts; and the manager's job was a blend of rights and duties.

Reports were found of three Canadian studies in which structured observation was used to study managerial work. These were: a study of small company managers completed under Mintzberg's supervision (Choran, Note 1), and studies of school superintendents (Duignan, 1979) and deans of nursing (Hannah, 1981) completed at the University of Alberta. The characteristics of managerial work as described by Mintzberg were generally supported by these studies, and the managerial roles developed by Mintzberg comprised a major portion of the work of these managers. Differences found for small company managers related to their involvement with daily operational activities and two additional roles: specialist and substitute operator. The school superintendents had daily, weekly and seasonal patterns to their work, rarely made decisions on their own, and spent about one-quarter of their time in educational leadership behaviors in addition to performing executive behaviors. Deans of nursing also had definite seasonal variations in their work, and made few unaided decisions. They consciously committed themselves to a set of scholarly behaviors in addition to the managerial roles; these behaviors included the roles of teacher, researcher and author.

Literature related to observational field studies in general was reviewed to determine strengths and limitations of such studies and to obtain further guidance regarding data collection and analysis procedures. Observational field studies are used when the researcher wishes to observe both the behavior and the setting within which it occurs. Although there are limitations to observational field studies, most of them can be at least partly offset, according to the literature.

5.1.2.3 Literature Related to the Setting for the Study

An observation method was chosen because the setting was considered pertinent to interpretation of the activity and behavior observed. Literature related to the historical development and current structure of Alberta community health services was reviewed to provide a description of the larger setting within which Alberta community health nursing managers work.

The range of community health services provided by the Alberta government has expanded, from what in 1905 was administered by one department which had other responsibilities, to what now entails administration by two full government departments. The provincial government has provided 100% of the funds for local community health services since 1973, but administration of the services was maintained at the local level and local autonomy is considered to be very important. Two-thirds of the 27 LHAs

were established approximately 25 to 30 years ago. Considerable turnover of long-term community health nursing managers has occurred in the past five years. The current official community health services "system" in Alberta is composed of 28 units (27 LHAs and the provincial department, Alberta Social Services and Community Health) which are loosely-coupled by a network of formal and informal relationships mostly developed during the last decade.

5.1.3 Summary of the Results of the Study

5.1.3.1 Structure of the Observed Health Units

All four Health Units which were observed had a Medical Officer of Health as Director, and had similar organizational structures. The four community health nursing managers each reported directly to the Medical Officer of Health, and, as stipulated in the Health Unit Act, each was the Acting Director of the Health Unit when the Medical Officer of Health was absent from the Health Unit.

Two of the observed Health Units were predominantly urban with a larger total population in comparison to the other two which were predominantly rural with a smaller total population and a smaller total staff. All four community health nursing managers stated that there was a shortage of support staff in their Health Unit. All of the Health Units located some staff in suboffices. In all four Health Units at least one move to a new building had

occurred recently or was being planned.

The community health nursing staff were unionized in two of the four Health Units; the community health nursing manager was part of the management negotiating team in both of these Health Units.

Formal documentation of policies and procedures varied considerably in the Health Units observed. Two of the four Health Units prepared a public annual report each year; two did not.

In two Health Units the Medical Officer of Health regularly delegated considerable responsibility to the community health nursing manager and expected considerable input into overall Health Unit administration; in the other two Health Units, very little responsibility for overall Health Unit administration was delegated.

Two community health nursing managers had two assistants who shared the responsibility for community health nursing staff and programs, one had one assistant and one did not have an assistant. The community health nursing managers supervised community health nurses and community health assistants. All community health nursing managers had some part-time staff; the total number of persons supervised ranged from 11 to 29. The majority of the community health nurses in these Health Units were generalists. In two Health Units almost all community health nurses had a baccalaureate nursing degree; in two about half of the community health nurses were registered nurses without community health

nursing educational preparation. Staff nurses' meetings were held regularly in all four Health Units.

Formal documentation of policies and procedures related to community health nursing programs varied. All four community health nursing managers stated that maintaining up-to-date manuals and written documentation was a continuing problem for them.

Three of the four community health nursing managers expressed concern regarding the poor or non-existent orientation they had received to their jobs as community health nursing managers.

The types of qualifications listed in the position description documents of the community health nursing managers were the same, but there was variation in the specified requirements within each type of qualification. Considerable similarity in the duties and responsibilities of the community health nursing managers as listed in these documents was found.

5.1.3.2 The Community Health Nursing Manager's Activities and Behaviors

The observed community health nursing managers worked a 7.6-hour day on average. In terms of type of activity, desk work and scheduled meetings took the largest proportions of time, and one or the other was the predominant type of activity for all four community health nursing managers. Unscheduled meetings and telephone calls were the next most

time-consuming types of activity overall; travel and tours required the smallest proportions of time during observation. Time required for travel was probably underestimated because travel outside the Health Unit was deliberately not scheduled during observation.

On average the community health nursing manager engaged in 39 activities per day, of which almost 70% lasted 9 minutes or less and only 3% lasted more than one hour. On average the community health nursing manager worked 12 minutes before being interrupted or changing to another activity. In handling mail, two-thirds of the time was spent on incoming mail and one-third on outgoing mail.

On average the community health nursing manager spent one-third of the day in solitary activities and two-thirds in joint activities. Two-thirds of this joint activity time was spent with persons within the Health Unit; one-third with persons from outside the Health Unit organization.

In terms of major category for administrative behavior, community health nursing managers spent the largest proportion of time on interpersonal behaviors, with informational, professional and decisional behaviors ranked in descending order after interpersonal behaviors. The single role to which the community health nursing manager allocated the most time was the leader role. Mintzberg's managerial roles described much of what the community health nursing manager did, but there was a set of behaviors which primarily required community health nursing expertise rather

than managerial expertise. These behaviors were termed professional behaviors, and were subdivided into three roles: professional leader, professional expert, and professional consultant.

Many of the variations among the activities and behaviors of the four community health nursing managers could be explained by the particular circumstances in the Health Unit at the time of observation, or by the structure of the particular Health Unit.

In the comparisons made with other structured observation studies of managers the community health nursing manager's results were more similar to those of the school superintendent and the dean of nursing than they were to those of the chief executive and the small company manager. For example, the average number of activities per day, the average numbers of various types of activities per day, and the proportion of short-duration activities per day were similar for the community health nursing manager, the school superintendent, and the dean of nursing. (See section 4.3 for further comparisons.) Frequently, the results of the chief executive and those of the small company manager formed the extremes of the range of results in a particular category of comparison; the results of the community health nursing manager, the school superintendent and the dean of nursing typically fell between these two extremes. The community health nursing manager's results showed close similarity to those of the school superintendent more often

than to those of the dean of nursing.

5.2 Conclusions

The study population was limited to full-time senior managers responsible for nursing programs in official community health agencies in Alberta who had at least baccalaureate-level education. Four community health nursing managers, all of whom were female, were observed for a total of twelve days during October and November 1982. The small sample size and the restricted study population limit the generalizability of the findings. However, the in-depth nature of the data and the use of composite profiles permit the activities and administrative behaviors of the community health nursing managers in this study to be described collectively, and give insight into the nature of the activities and administrative behaviors of some Alberta community health nursing managers at present. Two sets of conclusions follow: those regarding community health nursing management, and those regarding the methodology.

5.2.1 Conclusions Regarding Community Health Nursing Management

The community health nursing managers studied had few breaks in the pace of activity through the work day. Their work days were filled with a great number of short-duration activities which involved a variety of issues, and frequent

interruptions required change of focus to activities related to other issues.

A larger proportion of time was spent in joint activities than in solitary activities by the community health nursing managers studied. These joint activities provided the link between the community health nursing unit and numerous other persons both inside and outside the Health Unit.

The observed community health nursing managers experienced conflict between their responsibility for community health nursing staff and programs, and their responsibility in relation to total Health Unit administration. The community health nursing managers stated that they had to work at ensuring that the community health nursing programs and staff were not deprived of the time they required.

There are reported seasonal, but not definitive daily or weekly, patterns to the observed community health nursing managers' work. Daily work showed considerable variation. Changes occurred when the assistant or the Medical Officer of Health was away from the Health Unit. Other factors which were reported as effects on the pattern of work were budgeting, preparation of the annual report, and program planning.

Community health nursing managers who were studied spent a significant amount of time on professional behaviors. This major category of administrative behavior

involved an average of 15% of the community health nursing managers' time, and was a definite pattern with all four community health nursing managers. This finding was not unexpected as Duignan concluded that there was a distinction between executive and educational behaviors for school superintendents, and Hannah concluded that deans of nursing performed scholarly behaviors in addition to administrative behaviors. The finding regarding community health nursing managers lends further support to the conclusion reached by Hannah:

> there are core elements of administration which are universal among all types of administration but . . . there are also additional elements which are unique to specific types of administration (1981, p. 282).

Based on these studies it would appear that this conclusion is valid at least for management in publicly-funded human service organizations.

The largest proportion of the observed community health nursing managers' time was spent in interpersonal behaviors, and of these the leader role was predominant. The leader role was allocated at least one-quarter of the time by three of the four community health nursing managers. It is not known whether this role was emphasized because the community health nursing managers considered it to be the most important, because they felt best prepared or most comfortable with this role, or because there was most pressure to assume the leader role.

The observed community health nursing managers were very independent and, to some extent, isolated. Their positions have been developed independently in each Health Unit. These community health nursing managers did not receive an orientation to their jobs, and none of them had ever had their performance evaluated by the Medical Officer of Health or the Board. The feeling of isolation was indicated by such comments as the following two examples. One community health nursing manager commented that "there's no real help for the Supervisor--one day you're a good community health nurse, the next you're a Supervisor." Another expressed the concern as "isolation is a problem in this job."

All the community health nursing managers studied commented on the lack of support staff in their Health Units. It is not known if this shortage contributed to the high proportion of time the community health nursing managers spent on desk work.

The distinction made by Brancich and Porter (1979) between the semidirect client service provided by supervisory staff and the indirect client service provided by the nursing director seems to describe two important dimensions of the roles which the observed community health nursing managers had developed for themselves and their assistants.

This study of the activities and behaviors of community health nursing managers describes what was being done by

these managers at the time of observation. Although the observed similarities indicate some consensus regarding the current role, normative conclusions regarding what "ought to be" done in community health nursing management cannot be made as a result of this study.

5.2.2 Conclusions Regarding Methodology

It is concluded that the structured observation field study approach was appropriate for this study. The detailed and comprehensive data collected could not have been obtained as efficiently and effectively by other methods.

The subjects' knowledge that the researcher was a community health nurse, and their positive experience with her in a previous study increased their willingness to participate in this study, according to the Director of Community Health Nursing. These factors also appear to have decreased the observer interference effect. Statements made by the community health nursing managers, such as "when I heard it was one of us" and "it's nice to have a colleague to talk to" support this conclusion. When asked about the disruptiveness of the observation as related to accomplishing their work, the community health nursing managers commented that, although they remained aware of an observer's presence much of the time, they did not find it to be disruptive. This would also seem to indicate that the unobtrusive, limited interaction observer role which the researcher attempted to use was, for the most part, achieved

and was effective in decreasing observer interference. One community health nursing manager reported that a staff member had commented to her: "Gee, you're lucky, your shadow's low-key."

Bias due to observer interference and faulty observer inference was minimized because this reseacher had community health nursing knowledge. Although there were discussions with the community health nursing managers relating to the activities being performed, only 12% of the subjects' actual working time was spent with the researcher, and this included the time spent introducing procedures to be used in this study and in the interview at the end of the observation. The amount of time spent with the researcher was not reported by Mintzberg, Choran, Duignan or Hannah. The only researcher to explicitly refer to such time was Choran, who stated that his "lack of technical knowledge was obvious" so he had to ask many questions (Note 1, pp. 51, 57), and that "any time spent talking to the researcher was deducted [from working time]" (p. 139).

The considerable consistency of findings for the four community health nursing managers can on the one hand suggest that "typical" activities were observed; or, it could be argued that if the observer affected the activities engaged in, the effect was close to the same for all four community health nursing managers. Several of the differences which occurred were pointed out by the community health nursing managers during the interviews when they were

asked what had not been typical during the three days of observation. The finding that some of the activities which did not occur for one or two community health nursing managers did occur for the others supports the conclusion that the composite description of the community health nursing manager's activities and behaviors is a reasonably valid description of the overall work of these managers. It would also appear that the categories used in analysis provided reasonable discrimination among activities and behaviors, or there would not have been differences among the four community health nursing managers.

Although the structured observation method used was considered appropriate for this study, the method emphasizes fragmentation of managerial work, and underemphasizes linkage of activities. For example, an activity which is interrupted and then resumed is counted as three activities according to this method. Further, it may be that managers deliberately choose to engage in numerous short contacts over a period of time rather than in few longer contacts. Long-term involvement in relation to an issue or problem cannot be determined by this method which yields a description of managerial work at one cross-section in time. The method used in this study yields descriptive information regarding what managerial work was being done at one point in time, but does not give information regarding the effectiveness of such work or prescriptive information regarding what work should be done.

5.3 Recommendations

Two sets of recommendations are listed: those related to community health nursing management and those related to further research.

5.3.1 Recommendations Related to Community Health Nursing Management

1. It is recommended that community health nursing managers examine the work characteristics as described in the molecular analysis sections of this report to determine if such work characteristics are appropriate for accomplishing their goals.
2. It is recommended that community health nursing managers examine the categories of behavior described in the molar analysis sections of this report to determine if such a framework would assist them in setting their work priorities.
3. It is recommended that community health nursing managers and Health Unit Directors use the categories of behavioral roles as a framework for job descriptions for the community health nursing manager position.
4. It is recommended that community health nursing managers examine the appropriateness of the proportion of time spent on desk work to determine whether more or different clerical support would be beneficial to them.
5. It is recommended that community health nursing managers systematically document their work and their problems,

and write and publish their findings and recommendations regarding their perceptions of the role of the community health nursing manager, of issues relevant to community health nursing management, and regarding strategies, tools and procedures which are useful in community health nursing management.

5.3.2 Recommendations Related to Further Research

1. It is recommended that the activities and administrative behaviors of community health nursing managers in large Local Health Authorities be studied to permit comparisons with those of community health nursing managers in the small and medium-sized Local Health Authorities used in this study.
2. It is recommended that studies be made of community health nursing managers in provinces other than Alberta so it can be determined to what extent the community health system affects the role of the community health nursing manager, and to what extent the findings of this study are typical of community health nursing managers in other provinces.
3. It is recommended that a study of activities and administrative behaviors be conducted with hospital nursing managers. Results could be compared to those of community health nursing managers (this study) and to those of nursing education managers (Hannah, 1981).

Similarities and differences among these managers could be used in determining the types of basic and continuing education of nursing managers needed in relation to differing work settings.

4. It is recommended that a study be made of the Canadian Nurses' Association standards for nursing administration (in press), which are focused on the general area of nursing administration to determine their suitability for and applicability to community health nursing management.
5. It is recommended that a study similar to this one be made on the same population after a period of time to determine if changes occur over time in the activities and administrative behaviors of community health nursing managers.
6. It is recommended that the methodology used in this study be rigorously critiqued as a basis for development of a better methodology for studying the linkage of managerial activities and the manager's long-term involvement with specific issues and problems.

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APPENDIX A. MAP OF ALBERTA LOCAL HEALTH AUTHORITIES

Alberta
CANADA

HEALTH UNITS
LOCAL BOARDS OF HEALTH
1980

COLOURED AREAS DENOTE HEALTH UNITS

• HEALTH UNIT HEADQUARTERS

APPENDIX B. COMMUNICATION WITH STUDY PARTICIPANTS

1. Letter to Potential Study Participants from Director, Community Health Nursing
2. Letter to Potential Study Participants from Researcher
3. Letter to Subjects Confirming Participation
4. Letter to Alternates Confirming Participation
5. Article in Community Health Nursing Bulletin
6. Letter Thanking Subjects
7. Letter Thanking Alternates

Alberta

SOCIAL SERVICES
AND COMMUNITY HEALTH

In Replying Please Quote:

Seventh Street Plaza
10030 - 107 Street
Edmonton, Alberta, Canada
T5J 3E4

August 18, 1982

Dear

Enclosed is a letter from Mrs. Pearl Morrison which describes the study she is conducting for her thesis in Health Services Administration. You will recall that Pearl worked with the Nursing Directorate during the summer of 1981, and did the survey this spring regarding utilization of ACNARS Reports.

Her criteria for selection of nursing managers require knowledge of the LHAs and the confidential staff preparation survey. Therefore, rather than break confidentiality, I am asking the few of you who meet the criteria to let me know if Pearl may contact you regarding the study.

I strongly encourage you to agree to participate, as I have every confidence that Pearl's thesis work will be of high quality and that she will respect confidentiality. I will be out of the office a fair bit next week, so I will try to call you on Friday, August 27, regarding your willingness to discuss the study with Pearl.

Sincerely

Phyllis M. Craig

(Miss) Phyllis Craig
Director
Community Health Nursing

Enclosure

/rg

11431 - 32 Avenue
Edmonton, Alberta
T6J 3G5
August 18, 1982

Dear Director/Supervisor of Nursing:

I am writing to request your participation in a study of the administrative activities, behaviors and roles of community health nursing (CHN) managers in Alberta. This project is the focus of my thesis for a Master's degree in Health Services Administration at the University of Alberta. The information derived should be helpful in preparation of educational programs for CHN managers, in recruitment of new CHN managers, and in assisting CHN managers to determine how to obtain the information needed to function more effectively.

Collection of data for this field study involves non-participant observation; that is, I will observe CHN managers while they perform their regular work. Thus, participation in the study means allowing me to be your "shadow" for a period of three days in October or November 1982 and to meet for approximately a half-hour to sum up at the end of the three days. There may be certain situations which those involved would prefer not be observed (e.g., performance appraisal interviews), and I will withdraw from observation immediately upon the manager's request.

The data collected during observation will be used only for this thesis, and the identity of the participants will not be discussed with anyone or reported in the thesis. The data to be collected relate to the process of managerial activities (e.g., type of activity--meetings, desk work, etc.; duration; primary purpose; type of decisions made). The data collected will be purely descriptive in nature, and will not include information regarding the detailed content of the work, the managerial style, nor any evaluation of the manager.

In order to describe the regular, ongoing work of "typical" CHN managers, it is necessary to randomly select four participants from those CHN managers who meet the following criteria:

1. currently employed full-time as a community health

nursing manager in an Alberta Local Health Authority (LHA; excluding Edmonton and Calgary),

2. has held this job full-time on an uninterrupted basis for the past calendar year,

3. is a baccalaureate-prepared nurse,

4. is in an LHA which has ongoing community health nursing programs but no treatment programs,

5. has an LHA Director who has been in the position for at least one year, and

6. is willing to participate in the study.

Some of the information required regarding these criteria is confidential in nature. Therefore, Phyllis Craig, Director of Community Health Nursing, is mailing my letter to those who meet the criteria (without informing me of who does and who doesn't). Would you please let Phyllis know whether or not you are willing to discuss participating in the study with me? I will then be able to randomly select those who will actually take part in the study from the group who meet the criteria.

I hope that you will be willing to participate in this study. I look forward to talking with you.

Sincerely,

Pearl M. Morrison, RN,
BScN, MHSA Candidate

11431 - 32 Avenue
Edmonton, Alberta
T6J 3G5
September 8, 1982

Name

Address

Dear

Thank you for agreeing to participate in my research study of the administrative behaviors of Alberta community health nursing managers. I am writing to confirm the dates for observation which we discussed by telephone on Friday. I will visit you Local Health Authority on October _, _, and _, 1982. I plan to be at your office between 8:30 and 9:00 a.m. on the first day.

I appreciate your willingness to participate in this study and look forward to seeing you next month.

Sincerely,

Pearl M. Morrison, RN,
BScN, MHSA Candidate

11431 - 32 Avenue
Edmonton, Alberta
T6J 3G5
September 8,1982

Name

Address

Dear

Thank you for your willingness to participate as an alternate in my research study of the administrative behaviors of Alberta community health nursing managers. I am writing to confirm that, as we discussed by telephone on Friday, you were chosen as an alternate for the study in case someone cannot participate during October 1982. I will telephone you as soon as I know whether or not your participation will be necessary.

Thanks again for your co-operation.

Sincerely,

Pearl M. Morrison, RN,
BScN, MHSA Candidate

Pearl Morrison's Study "A Descriptive Study of the Administrative Behavior of Alberta Community Health Nursing Managers"

Pearl Morrison will soon be undertaking a study of the administrative activities, behaviors and roles of community health nursing (CHN) managers in Alberta. The study is the focus of her thesis for a Master's degree in Health Services Administration at the University of Alberta. Information derived should be helpful in preparation of educational programs for CHN managers, in recruitment of new CHN managers, and in assisting CHN managers to determine how to obtain the information needed to function more effectively.

Collection of data for this field study involves non-participant observation; that is, observation of CHN managers while they perform their regular work. Data to be collected relate to the process of managerial activities (e.g., type of activity--meetings, desk work, etc.; duration; primary purpose; type of decisions made). The data collected will be purely descriptive in nature, and will not include information regarding the detailed content of the work, the managerial style, nor any evaluation of the manager. Data collected will be used only for the thesis, and the identity of the participants will not be discussed with anyone or reported in the thesis.

In order to describe the regular, ongoing work of "typical" CHN managers, it is necessary to randomly select four participants from CHN managers who meet the following criteria:

1. currently employed full-time as a community health nursing manager in an Alberta Local Health Authority (LHA), excluding Edmonton and Calgary,
2. has held this position full-time on an uninterrupted basis for the past calendar year,
3. is a baccalaureate-prepared nurse,
4. is in an LHA which has ongoing community health nursing programs but no treatment programs provided by community health nurses,
5. has an LHA Director who has been in the position for at least one year, and
6. is willing to participate in the study.

The CHN managers who met the criteria were contacted by Phyllis Craig to obtain permission for their names to be given to Pearl Morrison, who will randomly select and then contact actual study participants. Pilot study observations with other CHN managers were conducted in August 1982. Analysis of the pilot study data and refinement of procedures was to be done during September. Observation of

study participants was done in October and November; analysis of the data will take two to three months. Mrs. Morrison expects to complete the thesis by spring 1983.

Most CHN managers will have met Pearl Morrison either during the summer of 1981 when she worked with the Nursing Directorate, or in relation to the 1982 survey regarding utilization of ACNARS Reports.

P. Morrison

11431 - 32 Avenue
Edmonton, Alberta
T6J 3G5
November 19,1982

Name

Address

Dear _____

Thank you very much for having been a participant in my research study of the administrative behavior of Alberta community health nursing managers. I have now completed the observation-data collection phase of the study, and will be analyzing the data and writing the thesis over the next few months. I expect to complete my thesis by spring 1983.

I certainly could not have undertaken a study such as this without the active participation of persons like you, and I do appreciate your interest and willingness to share your knowledge and experience with me. Thanks again.

Sincerely,

Pearl M. Morrison, RN,
BScN, MHSA Candidate

11431 - 32 Avenue
Edmonton, Alberta
T6J 3G5
November 19,1982

Name

Address

Dear

As I told you by telephone I have completed the observation of the administrative behaviors of Alberta community health nursing managers for my research study. Since the observation phase is now complete I will not require your active participation in the study. Over the next few months I will be analyzing the data collected and writing my thesis. I expect to complete the thesis by spring 1983.

Thank you for having been willing to participate in this study. I do appreciate your interest.

Sincerely,

Pearl M. Morrison, RN,
BScN, MHSA Candidate

APPENDIX C. GUIDES FOR DATA COLLECTION AND ANALYSIS

1. Coded Observational Record
2. Coded Mail Record
3. Coded Telephone Record
4. Interview Questions
5. Daily Summary Sheet for Data Analysis

OBSERVATIONAL RECORD - CHN MANAGER C, DAY D, 82-10-DAY

Time	Participants	Initiator Self	Initiator Other	Type of Activity	Purpose	Code	Duration (minutes)	Comments
8:05	self	x		desk w.	sort papers on desk	C-D-1	3	
8:08					get mail from MOH		4	
					mail A to H (from MOH)			
8:12	CHN		x	uns. mtg.	Further Ed. booklet; transportation grants	C-D-2	7	
8:19	self	x		desk w.	mail I to L (from MOH)	C-D-3	3	
8:22					mail to front office		1	
8:23	secretary	x		uns. mtg.	Dr's app't and followup	C-D-4	1	
8:24	Speech Ther.	x		uns. mtg.	re: ECS mtg. in one community in Nov.	C-D-5	2	
8:26	self	x		desk w.	mail to boxes and sec'y	C-D-6	3	
8:29	CHN	x		T-1		C-D-7	17	
8:46					coffee break		24	unclass.
9:10	self	x		desk w.	pick up mail, sort	C-D-8	5	
					mail L1 to L4		3	
					Xerox M,N,O--copy to Home Care and P.H. Inspector		6	
9:24					mail M,N,O		2	
9:26					skim population reports from municipalities		9	
9:35					mail P,Q,R		2	
9:37	sec'y-suboff.	x		T-2		C-D-9	1	
9:38	self	x		desk w.	mail S to V	C-D-10	8	
9:46					mail W, X		4	
9:50	sec'y-suboff.	x		T-3		C-D-11	1.5	
9:51	self	x		desk w.	get physical assessment info. from file (for CHNs)	C-D-12	4	
9:55	CHN	x		T-4		C-D-13	0.5	
	CHN	x		T-5		C-D-14	0.5	
9:56	self	x		desk w.	to do list for today	C-D-15	1	
9:57	CHN		x	uns. mtg.	discuss Family Life Education form	C-D-16	9	

OBSERVATIONAL RECORD - CHN MANAGER C, DAY D, 82-10-DAY

Time	Participants	Initiator Self	Initiator Other	Type of Activity	Purpose	Code	Duration (minutes)	Comments
10:06	self	x		desk w.	redraft Family Life Education form;	C-D-17	17	
10:23					sort desk, add to list;		2	
10:25					mail to MOH's desk;		3	
10:28					typing, mail and filing-sec'y mail Y		6	
10:34	Administrator	x		T-6		C-D-18	very brief	
	Administrator	x		T-7		C-D-19	25	
10:59	municipality	x		T-8		C-D-20	1	
11:00	sec'y-suboff.	x		T-9		C-D-21	4	
11:04	self				note made		1	
11:05	Dir. of Hosp.	x		T-10		C-D-22	3	
11:08	sec'y-suboff.	x		T-11		C-D-23	4	
11:12	self				note made		1	
11:13	self	x		desk w.	resume notes to staff from yesterday	C-D-24	16	
11:29	CHN		x	uns. mtg.	left referrals from hospital visit	C-D-25	0.5	
	sec'y		x	uns. mtg.	discussed pamphlet; asked sec'y to tell Home Care Coord.	C-D-26	1.5	
11:31	researcher	x		uns. mtg.	discussed reference material for child dev. and prenatal		6	personal -unclass.
11:37	self	x		desk w.	resume notes to staff	C-D-27	2	
11:39	Administrator		x	T-12		C-D-28	2	
11:41	self				notes re: previous call		3	
11:44	self	x		desk w.	resume notes to staff	C-D-29	1	
11:45	CHN-suboff.		x	T-13		C-D-30	10	
11:55	self				notes made re: TV program		3	
11:58	self	x		desk w.	mail Z	C-D-31	3	
12:01					look at hospital referrals		2	
12:03					lunch break			unclass.

MAIL RECORD - CHN MANAGER __, DAY __, 82-10-DAY

Code	Correspondent	Type	Purpose	Action Taken	Duration
A C-D-1	staff member	form	vacation form signed	return to staff member	A to H
B	ASSCH	letter	adverse reaction	in filing pile	4
C	Vital Stats	form	death notice	for filing	
D	staff members	forms	sick leave (signed)	to Admin.+staff members	
E	AADL (ASSCH)	letter	Re: CHN orientation	note on letter	
F	Mental Health Council	letter + brochure	want HU participation in survey; MOH agreed	to work file	
G,H	self	memo (2)	notes to MOH	to own file (keeps copy)	
I C-D-3	self	letter	re: Family Life Education	to nurse's mtg. file	I to L
J	Prov. Lab.	report	re: diphtheria	to sec'y for filing	3
K	outside org.	newsletter	information	to library	
L	outside org.	letter copy	information	to Home Care Coordinator	
L1,L2,L3	staff members	form (3)	time sheets for staff	signed; to Admin.	L1 to L4
L4 C-D-8	optometrist	form	report re: child sent for vision check	skimmed; to CHN	3
M,N,O	3 different municipalities	report (3)	1982 report of population	skimmed; filed in population file	M to O 8
P	staff member	form	expense account	to MOH for signing	P to R
Q	staff member	form	vacation time	for filing	2
R	CHN	form	request vacation	T-2 to check dates	
S C-D-10	hospital	referral	new infant born there	coded for risk factors	S to V
T	University	letter	invitation to practicum evaluation, reception	one for CHN manager; one for MOH	8
U	Prov. Lab.	report (2)	re: Salmonella	to MOH	
V	another LHA	report	1981 Annual Report	skimmed; to MOH	
W	outside org.	catalogue	films available	to add to staff notes	W, X
X	secretary	brochures	new pamphlets received	pamphlets to resource file, note to secretary	4
Y C-D-17	ASSCH	report	1982 HU population info. used by province	read; found error (in relation to own); T-7	6
Z C-D-31	self	memo	re: pertussis TV program	result of T-13	3

TELEPHONE RECORD - CHN MANAGER __, DAY __, 82-10-DAY

	Code	Participant	Purpose	Result	Duration
1	C-D-7	CHN-suboffice	discuss school work and Family Life Education; CHC app'ts; home visits; overtime	requested information; consultation with staff member	17
2	C-D-9	sec'y-suboffice		no answer	1
3	C-D-11	sec'y-suboffice	leave message for CHN	wrong number; no answer	1.5
4	C-D-13	CHN		line busy	0.5
5	C-D-14	CHN		line busy	0.5
6	C-D-18	Administrator		no answer	very brief
7	C-D-19	Administrator	discuss error in population figures rec'd from province; 1983 estimates of pop.; waiting for school census; know number of Lodge beds	will phone municipality re: letter to ASSCH; will give Administrator copies of pop. info. when all is rec'd	25
8	C-D-20	municipal secretary	check his population information	he's not in until tomorrow; will call then	1
9	C-D-21	sec'y-suboffice	contact CHN sec'y is part-time-keeping track of phone calls	message left note of info. re: phone calls	4
10	C-D-22	Director of Hospital	on behalf of MOH; re: stool specimens of food handlers	gave information	3
11	C-D-23	sec'y-suboffice	discuss workshop attendance	message for part-time CHN	4
12	C-D-28	Administrator	hotels in Edmonton (HUAA); discussed Board member's resignation (was Home Care Advisory Comm. Chairman)	gave information	2
13	C-D-30	CHN-suboffice	discussed videotapes (physical exam, DDST); pertussis--TV program on Sun. re: U.S. mom who feels her child was brain-damaged by pertussis vaccine; numerous calls since then	gave information re: CHN who will demonstrate physical assessment; discussed arrangements for videotapes; rec'd information re: pertussis	10

INTERVIEW QUESTIONS

1. To what extent do you think this three-day period has been typical of your usual activities? What has not been usual or typical?

2. What activities are you typically involved in that I have not observed?

3. As you know I will be observing CHN managers in other LHAs in Alberta. Can you think of any unique features of your LHA which might affect your work as CHN manager?

4. I know there's a lot of seasonal variation in community health nursing staff's work. Would there be much seasonal variation in <u>your</u> work? (Is there a "typical" month?)

5. How much time outside of normal working hours do you spend on work-related activity in one week?

6. How disruptive did you find my presence here in terms of being able to accomplish your regular work? How long was it before you felt reasonably settled (observer not causing undue anxiety)?

7. How do you think my presence here has affected the work of others in this LHA (i.e., your staff)?

8. How many days do you think I would need to observe to have a good picture of the work of a CHN manager?

9. If I think of other questions I want to check with you, is it okay to telephone you later from Edmonton? If you think of something you think I should know, write or call me at __.

DAILY SUMMARY SHEET

CHN MANAGER_____ DAY_____
DURATION OF DAY (Minutes)_____ (____ Hours) TOTAL ACTIVITIES FOR DAY_____
RANGE OF DURATION OF ACTIVITIES FOR DAY_____ AVERAGE DURATION OF ACTIVITIES FOR DAY_____

	Total Time (Minutes)	Total Units of Activity	Average Duration of Activities	Time for Activity as % of Total Day	Activities as % of Total Day's Activities
CLASSIFICATION OF ACTIVITIES BY TYPE:					
TOTAL					
Desk work					
Telephone calls					
Scheduled meetings					
Unscheduled meetings					
Tours and visits					
Travel					
Unclassified					
CLASSIFICATION OF ACTIVITIES BY PARTICIPANTS:					
Solitary activities					
Joint activities					
Within LHA					
Superordinates					
Deputy					
Subordinates					
Peers					
Other					
Outside LHA					
Government					
Other organizations					
and other LHAs					
Public					
Researcher					

APPENDIX D. DETAILED RESULTS OF STUDY

1. Community health nursing managers' types of activity by time
2. Duration of activities of community health nursing managers by number of activities
3. Community health nursing managers' activities by category of participant
4. Participants in community health nursing managers' joint activities by time
5. Participants in community health nursing managers' joint activities by proportion of time
6. Community health nursing managers' major categories of behavior by time
7. Community health nursing managers' categories of behavior by average time per day
8. Community health nursing managers' categories of behavior by proportion of time

Appendix D.1

Community Health Nursing Managers' Types of Activity by Time

Category	Mean	Community Health Nursing Manager 1	2	3	4
TOTALS DURING OBSERVATION:					
-time worked	1368	1275	1298	1494	1405
-hours worked	23	21	22	25	23
-number of activities	118	143	94	126	109
AVERAGE TIME PER DAY IN:					
-desk work	138	226	79	166	83
-telephone calls	56	53	30	96	44
-scheduled meetings	121	53	154	99	178
-unscheduled meetings	78	56	58	97	100
-tours and visits	7	3	14	3	9
-travel	23	1	62	-	29
-unclassified[a]	33	33	36	37	26

Note. All times (except hours worked) are in minutes and have been rounded to the nearest minute.
[a]Interactions with secretaries or personal activities.

Appendix D.2

Duration of Activities of Community Health Nursing Managers by Number of Activities

Duration of Activities	Mean	Community Health Nursing Manager			
		1	2	3	4
0 - 5 minutes	22	28	17	22	20
6 - 10 minutes	6	9	5	6	6
11 - 30 minutes	8	8	6	11	7
31 - 60 minutes	2	3	2	2	2
61+ minutes	1	-	1	1	2
Total number of activities	39	48	31	42	37

Appendix D.3

Community Health Nursing Managers' Activities by Category of Participant

Category	Mean	Community Health Nursing Manager 1	2	3	4
AVERAGE TIME PER DAY:					
-in solitary activities	161	226	141	166	108
-in joint activities	262	166	256	295	334
-internal participants	172	121	189	137	240
-external participants	91	44	67	158	94
AVERAGE NUMBER PER DAY:					
-of solitary activities	14	21	9	15	13
-of joint activities	25	27	22	27	23
-internal participants	17	20	15	17	15
-external participants	8	7	7	10	8

Note. All times are in minutes and have been rounded to the nearest minute.

Appendix D.4

Participants in Community Health Nursing Managers' Joint Activities by Time

Category of Participant	Mean	Community Health Nursing Manager 1	2	3	4
AVERAGE TIME PER DAY WITH INTERNAL PARTICIPANTS:					
-superordinates	36	10	15	54	68
-deputy	54	40	43	-	132
-other subordinates	45	39	82	31	28
-peers	15	15	25	21	1
-other internal persons	21	18	24	32	12
WITH EXTERNAL PARTICIPANTS:					
-government	19	2	1	58	16
-other organizations, including other LHAs	19	1	21	46	6
-public	1	-	-	3	2
-researcher	52	41	44	51	70

Note. All times are in minutes and have been rounded to the nearest minute.

Appendix D.5

Participants in Community Health Nursing Managers' Joint Activities by Proportion of Time

Category of Participant	Mean	Community Health Nursing Manager 1	2	3	4
PROPORTION OF JOINT ACTIVITY TIME WITH INTERNAL PARTICIPANTS:					
-superordinates	14%	6%	6%	18%	20%
-deputy	20%	24%	17%	-	40%
-other subordinates	17%	23%	32%	10%	8%
-peers	6%	9%	10%	7%	0[a]
-other internal persons	8%	11%	9%	11%	3%
EXTERNAL PARTICIPANTS:					
-government	7%	1%	1%	20%	5%
-other organizations, including other LHAs	7%	1%	8%	16%	2%
-public	0.4%	-	-	1%	0[a]
-researcher	20%	25%	17%	17%	21%

[a]When rounded to the nearest whole number, rounds to zero.

Appendix D.6

Community Health Nursing Managers' Major Categories of Behavior by Time

Major Category of Behavior	Mean	Community Health Nursing Manager 1	2	3	4
AVERAGE TIME PER DAY IN:					
Interpersonal behaviors	171	151	199	143	189
Informational behaviors	90	89	48	152	73
Decisional behaviors	49	29	53	36	78
Professional behaviors	62	85	52	80	32
This study--behavior unclassified	51	38	44	51	71

Note. All times are in minutes and have been rounded to the nearest minute.

Appendix D.7

Community Health Nursing Managers' Categories of Behavior by Average Time per Day

Category of Behavior	Mean	Community Health Nursing Manager 1	2	3	4
INTERPERSONAL:					
Figurehead	22	34	12	37	6
Leader	117	110	148	37	173
Liaison	32	8	39	69	11
INFORMATIONAL:					
Monitor	55	52	44	58	66
Disseminator	18	6	3	55	5
Spokesman	18	31	0[a]	38	2
DECISIONAL:					
Entrepreneur	14	6	47	1	2
Disturbance Handler	19	6	-	25	46
Resource Allocator	12	17	7	8	14
Negotiator	4	-	-	2	16
PROFESSIONAL:					
Professional Leader	10	13	8	8	10
Professional Expert	27	15	19	67	7
Professional Consultant	26	57	26	6	14
UNCLASSIFIED:					
This Study	51	38	44	51	71

Note. All times are in minutes and have been rounded to the nearest minute.

[a]When rounded to the nearest whole number, rounds to zero.

Appendix D.8

Community Health Nursing Managers' Categories of Behavior by Proportion of Time

Category of Behavior	Mean	Community Health Nursing Manager 1	2	3	4
INTERPERSONAL:					
Figurehead	5%	9%	3%	8%	1%
Leader	28%	28%	37%	8%	39%
Liaison	8%	2%	10%	15%	2%
INFORMATIONAL:					
Monitor	13%	13%	11%	13%	15%
Disseminator	4%	2%	1%	12%	1%
Spokesman	4%	8%	0[a]	8%	0[a]
DECISIONAL:					
Entrepreneur	3%	2%	12%	0[a]	0[a]
Disturbance Handler	4%	1%	-	5%	10%
Resource Allocator	3%	4%	2%	2%	3%
Negotiator	1%	-	-	0[a]	4%
PROFESSIONAL:					
Professional Leader	2%	3%	2%	2%	2%
Professional Expert	6%	4%	5%	14%	2%
Professional Consultant	6%	14%	7%	1%	3%
UNCLASSIFIED:					
This Study	12%	10%	11%	11%	16%

[a]When rounded to the nearest whole number, rounds to zero.

Alberta
ENERGY AND NATURAL RESOURCES
Alberta Bureau of Surveying & Mapping

50th Street Atria, 4949 - 94B Avenue, Edmonton, Alberta, Canada T6B 2T5

File: MMP02-01
April 13, 1983

Ms. Pearl Morrison
11431-32 Avenue
Edmonton, Alberta
T6J 3G5

Dear Ms. Morrison:

RE: 1980 Alberta Health Units Map

Further to your telephone conversation with Mr. C.W. Youngs, this will grant you permission to use the above captioned map in your Masters Thesis report.

I understand that you have purchased copies of this map from our Map Distribution office and that these copies, and not reproductions, will be included in your thesis.

Truly yours,

E.A. Kennedy
Director, Mapping Branch

EAK/mmr